Evaluation of Wisconsin's Well Woman Program

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Executive Summary

The Wisconsin Well Women Program (WWWP) provides selected screening tests and follow-up diagnostic work for breast and cervical cancer. An Expanded Component of the program also provides selected screening tests and diagnostic work for high blood pressure, cholesterol, diabetes, depression, domestic abuse, and osteoporosis. Soon the Expanded Component of the program will also offer multiple sclerosis services and education. This is a new program component added by the Wisconsin legislature in the 2003-05 biennial state budget. The WWWP helps to identify --but not to treat-- medical conditions. It does not pay for treatment if screening and diagnostic tests identify a need for treatment; however, women who are diagnosed with breast or cervical cancer through the program are usually automatically eligible to enroll in Medicaid for the duration of their cancer treatment.

Women are eligible for the WWWP if they are low income (at or below 250% of the federal poverty level), uninsured or underinsured. Medicaid participants, including participants in the Family Planning Medicaid waiver, are not eligible for the WWWP.

The WWWP serves women age 35 and older, although the primary target group for breast cancer screening is women ages 50 to 64. Women older than 64 also may be served if they are unable to pay the Part B Medicare premiums. Although the WWWP generally does not serve women younger than 35, a pilot WWWP project in Milwaukee serves women starting at age 30 if they have a maternal family history of breast cancer.

Purpose

The Division of Public Health, which is responsible for administering the WWWP, requested that we review the program in order to identify areas for program improvement. The specific goals of our review were to:

1. gain a clearer understanding from the local public health departments' (LPHs') and other partners' perspectives of the strengths and limits of the Well Women Program;
2. obtain a sufficiently detailed understanding of the nature, causes, and consequences of any issues LPH managers and staff and other partners may have; and
3. identify options the Department should consider for addressing the specific concerns noted.

We were interested in policy issues LPH managers and staff and other partners wanted to raise, as well as operational concerns and how the program has been administered at the state level.

Approach

In order to gather information on the WWWP we interviewed a variety of program partners and collected information LPHs and other partners provided to help us understand issues and evaluate options for program improvement. Interviews and document reviews were conducted August through October of 2004.

Persons interviewed included:

- Central office WWWP staff.
- Selected DPH central office staff. We spoke with staff responsible for the consolidated contract and for general administration, including the WWWP.
- Regional office contact persons for the WWWP. Staff in each of the regions was interviewed either in person or by phone. We also attended a meeting of the regional office directors to gain information about the program.
- Selected providers. Providers interviewed included Planned Parenthood, the City of Milwaukee's Breast and Cervical Cancer Awareness Program (MBCAP), and Marshfield Clinic staff in Phillips and Marshfield.
- Selected WWWP local coordinators. We interviewed coordinators for Milwaukee, Dane, Adams, Juneau, Sauk, Price, Fond du Lac and Sheboygan counties. In addition to these individual interviews, we attended the WWWP Northeast Regional Coordinators meeting to obtain feedback about the program. This meeting included WWWP coordinators for Menominee, Kewaunee, Waupaca, Oneida, Oconto, Green Lake, Marquette, Waushara, Manitowoc, Winnebago, Outagamie, Fond du Lac, Sheboygan, Calumet, Shawano, and Brown counties. Thus, except for Price and Oneida counties, the local coordinators interviewed were primarily from central, eastern and southern Wisconsin.
- EDS staff responsible for processing WWWP claims, enrollment and reporting forms and reimbursing providers.

We also reviewed a number of key documents. These included the WWWP Policy and Procedure Manual and web site; sample objectives from local agency/county consolidated contracts for 2004; interim progress reports for the federal breast and cervical cancer early detection program for FFYs 2004 and 2005; federal program guidelines for the breast and cervical cancer early detection program (CDC Program Announcement 02060); outreach, program enrollment and reporting materials provided by the WWWP local coordinators we interviewed; and selected WWWP Monthly Updates.

Conclusions

Initial issues identified by central office staff included instances in which women had been billed for services received through the WWWP, services that were not covered by the program, problems with reimbursing providers and a general perception that there was a need for better communication within the program. The local program coordinators, providers and other persons we spoke with consistently supported the WWWP goals and mission. They noted that the WWWP provided services that were very important for women and that these services would not be available to many women

without the WWWP. Coordinators also told us that administrative improvements had been made recently to the WWWP and that they were committed to working with the program in the future. Following is a summary of our findings.

1. Billing Women for Services

It is difficult to know how frequently women are billed for services received through the WWWP. Some coordinators we spoke with estimated that it might occur 10% of the time, a few coordinators told us this was happening less often than in the past, but others described recent cases in which women had been billed. One of the providers we interviewed said this was the worst problem they had with the WWWP.

We found that there is no way currently to guarantee that women receiving services through the WWWP will not be billed for services. This occurs because providers conduct tests or test interpretation methods not covered by the program and also because of WWWP reimbursement issues.

Even though WWWP providers assure that they will not do so in their Provider Agreements, we found that it is not unusual for WWWP providers to conduct tests or order test interpretation methods that are not covered by the WWWP without first notifying women that the service is not covered. This, in turn, places the women served at financial risk of being billed for services not covered by the program. It also can result in the medical practitioner not being reimbursed or fully reimbursed for services provided.

A number of factors increase the likelihood that providers will conduct tests or order test interpretation methods that are not covered by the WWWP without first notifying women enrolled in the WWWP. These include the limited number of services covered by the WWWP, misunderstandings concerning the nature of the program, providers not always knowing that their patients are enrolled in the WWWP, and the nature of current WWWP policies about which tests and test interpretation methods are covered by the program. Coverage of services under the WWWP currently conflicts with the medical practitioner's primary focus on providing services based on what services they feel women need as well as with their responsibility to offer treatment to women regardless of their ability to pay or source of payment. Some providers do not participate in the WWWP because of its reimbursement policies.

We also found that delays in reimbursing providers and differences between WWWP reimbursement policies and that of other major programs, such as Medicare, also contribute to women being billed for services received.

2. Expanded Component

We found that commitment to the Expanded Component is not strong and that the Expanded Component is not well implemented in many areas of the state. Some providers are not willing to provide the prevention office visit or other services included in the Expanded Component because no treatment is funded if problems were found. Consequently some WWWP local coordinators do not fully inform women of the

services available to them under the Expanded Component of the WWWP unless the coordinator is able to refer the woman to one of the WWWP providers who does offer the expanded services. Many of the persons we spoke with also questioned the services that were covered under the Expanded Component. They felt that some of the services covered by the Expanded Component were not as relevant to the age group of women served by the program as other services that were not covered. They also noted that the Expanded Component did not cover some screening tests such as tests for colon cancer that were more cost effective than some of the tests that were covered by the program. Some of the persons we spoke with also questioned why the Expanded Component did not cover tests in the area of reproductive health such as screening for ovarian cancer that were not covered by the breast and cervical cancer component of the program.

3. Communication and Coordination Among Various Parties

The WWWP relies upon a number of independent parties that need to coordinate their efforts and share information for the program to operate as intended. We found that communication problems have occurred between the different levels of state government and from the state to local practitioners. Our report includes suggestions and recommendations from program coordinators and providers to improve communication and overall program coordination.

4. Reporting Requirements

The WWWP is unique in requiring providers to report "results" for screening/diagnostic work in order to receive payment. Results are to be reported in the program activity reports. WWWP activity reports include the Activity Review Form and the Diagnostic and Follow Up Report Form. (These are referred as ARFs and DRFs.) The DPH contracts with EDS to process providers' claims, and EDS is responsible for processing and matching program enrollment and activity report forms to claims before paying claims. We found duplication in processing this information and a number of problems in implementing the requirement to link activity reporting with reimbursement.

5. Billing and Provider Reimbursement

Although several of the WWWP coordinators and providers we spoke with reported that the situation was improving, we still found widespread frustration with WWWP billing and provider reimbursement, including the unique WWWP activity reporting requirements.

6. Program Administration and Role of Various Partners

We found that local coordinators and central office staff were spending much of their time dealing with billing and reimbursement issues at the expense of other activities such as case management, quality assurance, outreach and provider education. Less than a third of the WWWP budget is used to reimburse screening providers.

7. Program Impact

A review of progress reports for the program in recent years shows that the program's strengths are in the areas of professional education, public education and outreach and partnerships. Areas needing improvement are management; screening, especially for

minority and never screened women; tracking, referral and follow up; and case management.

Program Description

The Wisconsin Well Women Program (WWWP) includes the federal National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and the former state-funded Well Women Health Screening Program (WWHSP). Breast and cervical cancer screening has been funded since 1994 under the NBCCEDP. In 1998, state funding became available for the additional expanded services. The Breast and Cervical Cancer Program and the Well-Woman Health Screening Program were combined in 2002.

The WWWP is located in the Division of Public Health, Bureau of Community Health Promotion, Section of Family Health. This section is also responsible for Preconceptional /Reproductive Health and Maternal /Perinatal Health as well as for 15 other programs. These other programs cover a variety of areas such as the Organ Donor Program, Injury Prevention and Adolescent Health. Another section in the Bureau of Community Health, the Chronic Disease & Cancer Prevention Section, is responsible for chronic disease and cancer control programs.

NBCCEDP Component of the WWWP

The state receives over $3 million annually from the federal Centers for Disease Control and Prevention (CDC) to support screening and selected follow up diagnostic testing for breast and cervical cancer through the NBCCEDP. CDC requires that at least 60% of this federal grant must be spent for breast and cervical cancer screening referral and follow-up for women with abnormal screening and no more than 10% for administrative functions. CDC also requires that 75% of women receiving mammograms through the WWWP must be 50-64 years old.

The federal NBCCEDP also allows screening services for cervical cancer for women starting at age 18. Wisconsin's program elected not to serve women younger than 35 because services were available to serve them through other programs. The specific breast and cervical cancer screening and diagnostic tests and test interpretation methods that may be covered by the program are determined by CDC federal policy. Wisconsin determines which of the services on the CDC approved list it will actually cover in its WWWP. The procedures that will be covered are specified in Wisconsin's NBCCEDP grant application to CDC.

The list of services that can be covered is updated periodically during the year by the CDC. The Wisconsin WWWP updates the list of covered services on an annual basis. The list of approved procedures covered by Wisconsin's program is usually updated following technical assistance input from the WWWP Clinical Issues Workgroup.

In addition, the Wisconsin Cancer Council serves as Wisconsin's medical advisory entity for the NBCCEDP. The Wisconsin Cancer Council is a coalition of 60 members, representing 30 organizations from across the state, who are dedicated to reducing cancer incidence and mortality in Wisconsin.[1] Per CDC policy, a state's medical advisory entity should be consulted whenever questions arise regarding the appropriateness or using a procedure not listed in a state's application. Decisions should be made based on "the overall intent of the CDC funding and amount of resources the program has available." It is expected that use of procedures not listed in the application will be an exception and used in less than 5% of the screening population.[2] The WWWP also receives assistance from the Wisconsin Cancer Council related to implementation issues for the program.

A key limitation to the program in the past was its inability to provide any treatment for identified conditions. Currently however, if a woman is diagnosed with breast or cervical cancer, it is likely she will be automatically eligible to enroll in Medicaid.[3] Then she can get comprehensive medical services as long as she is still getting active treatment for cancer. As soon as active treatment is completed, the woman is no longer eligible for Medicaid. She will be re-enrolled in WWWP and again able to receive the screening/diagnostic services covered by the WWWP.

In addition to screening and diagnostic testing, the NBCCEDP also provides case management related to breast and cervical cancer screening and diagnosis and specific components for public education and outreach, professional education, and quality assurance. As a condition of funding, states are also required to participate in the federal data collection and reporting system which tracks the women who are screened through diagnosis and follow up. The federal grant includes funding for program administration.

Expanded Component of the WWWP

Through the Expanded Component of the WWWP, state GPR funds (approximately $2 million annually) are also provided for breast cancer screening for women under age 50 and for screening for conditions other than breast and cervical cancer. However the funding for breast cancer screening for women under age 50 is currently used to fund local agencies through the consolidated contract. The Expanded Component of the WWWP covers tests for a variety of conditions including high blood pressure, cholesterol, diabetes, depression, domestic abuse, and osteoporosis. Soon the Expanded Component of the program will also offer multiple sclerosis (MS) services and education. Services and education for MS were added by the Wisconsin Legislature in the 2003-2205 biennial budget. When MS services were added, no additional GPR funds were allocated for MS services. Instead, $60,000 was carved out of existing state WWWP funding over a 2-year period.

The screening and diagnostic tests for the conditions covered by the Expanded Component are determined by Department policy. The Department also relies upon the advice of the WWWP Clinical Issues Workgroup to make final decisions about covered tests. Changes have occurred in the types of conditions covered under the Expanded Component of the WWWP over time. For example, the bone density test for osteoporosis is no longer covered. Program staff report that when the federal and state programs were

combined, they found it necessary to scale back the scope of the screening services offered in order to better manage the program. Thus some tests previously covered by the former state-funded Well Woman Health Screening Program such as the fecal occult test for colon cancer are no longer covered by the WWWP.

No treatment is provided for any of the conditions identified in the Expanded Component of the WWWP. However, local coordinators keep information on alternative resources (called the Essential Treatment Plan) that may be used to help women find resources for medical treatment for conditions identified other than breast and cervical cancer. We found that it is not unusual for WWWP certified providers to refuse to perform the screening tests included under the Expanded Component of the WWWP because no funds are available to treat conditions identified. Coordinators also reported that they refrain from telling women about the expanded services if they refer the woman to a provider who does not perform these screening tests. No summary data is available on the percent of the WWWP certified providers who agree to perform all of the tests covered under the Expanded Component of the WWWP. One of the coordinators we spoke with reported that only 3 of the 29 providers in their WWWP did so.

No funding is specifically designated to support administration for the Expanded Component of the WWWP. The Department's current biennial budget request for 2005-2007 includes a request to change current statutory language for the Expanded Component of the WWWP to authorize funding for case management and to better align program eligibility requirements with federal regulations.

Following is a summary of the breast and cervical cancer and expanded services provided by the WWWP.

Overview of Screening and Diagnostic Services Covered by WWWP

Service	Limitations (See notes below.)
Preventive Medicine Office Visit (initial or established)	Limited to 1 visit per provider per year and 2/client/yr.
Evaluation and Management Office Visit – Initial Patient (10, 20 or 30 minutes)	Only reimbursed to follow up on breast or cervical cancer diagnosis/screening.
Evaluation and Management Office Visit – Established Patient (5,10 or 15 minutes) Also called "problem focused" visit.	Permits 2 re-evaluations to follow-up on borderline or elevated blood pressure for established patient. Also reimbursed to follow up on breast or cervical cancer diagnosis/screening.
Consultation Office Visit-- (15, 30 or 40 minutes)	For breast diagnosis study only
Anesthesia	Based on "screening guidelines"
Depression Screening (Part of Preventive Medicine Office Visit)	
Depression Psychiatric Diagnostic Consult	Coded if assessment determines need for referral. Limited to 1/yr.
Domestic Abuse (Part of Preventive Medicine Office Visit)	
Cardiovascular Risk (Lipid panel or BP recheck)	Lipid panel every 5 years if no risk factors, every year if heart disease risk factor. One repeat lipid panel in 6 mos. if lifestyle change is the only recommendation.
Diabetes (FBG or random sample or GTT)	What will be reimbursed depends on age of woman and risk factors.
Osteoporosis (Part of Prevention Medicine Office Visit)	No longer pays for bone density tests.
Lab	(Venipuncture or supplies if > usual Office Visit) Venipuncture for "covered" lab test.
Breast Screening and Diagnosis.	1/yr or > based on "provider discretion." See notes.
Breast Lab	
Cervical Cancer Screening	Detailed discussion of what will be reimbursed in schedule. Depends on woman's risk factors, surgeries, etc.

Source: Combination of the Wisconsin Well Woman Program Screening Guidelines and Covered Services (April 1, 2003) and Reimbursement Rates (Effective 04/01/2004 – 03/31/2005).
Notes: WWWP does not reimburse for routine screening mammograms for women under age 50 who are not at high risk. Subsequent follow-up procedures are generally on an "as needed" basis except for "Breast Biopsy Interpretation" and "Excision of Lesions." These are limited to 5 specimens per procedure. More than 5 specimens must be pre-approved by the WWWP Service Delivery Coordinator.
Program does not cover services and procedures related to the treatment and management of any conditions diagnosed prior to a client's enrollment in the WWWP. Provider is responsible to tell client about WWWP not providing payment for any services, before providing that service.

Issues Related to Services Covered by the WWWP

We found confusion regarding which tests and test interpretation methods are covered by the WWWP. Several coordinators told us that misunderstandings about what the WWWP covers occur because people assume that the WWWP is an insurance program like Medicaid or Medicare and will fund comprehensive medical services. Others told us that the information disseminated to describe which services were covered by the WWWP is clear (i.e. program guidelines even indicate the specific medical codes for which services were covered), but the problem is that the program only covers a limited number of medical procedures. They noted that medical providers' primary focus is on providing services based on what services they feel women need instead of what procedures a specific program like WWWP covers.

WWWP policies about which services are covered also contribute to the confusion about which services are covered.

- The WWWP only covers selected screening and diagnostic tests related to some medical conditions. These medical conditions do not address a consistent area such as cardiovascular or reproductive health nor are they necessarily the areas of highest risk for the 50-64 age group of women primarily targeted by the WWWP. The screening tests covered by the WWWP include breast and cervical cancer, cardiovascular risk (high blood pressure and cholesterol), diabetes, osteoporosis, multiple sclerosis, and depression as well as domestic violence.
- For some of these conditions (depression, osteoporosis, and domestic violence) no laboratory work or medical tests are covered. The WWWP only covers screening for these conditions as part of a brief "prevention office visit" which is covered by the program.
- The WWWP covers most --but not all --follow-up diagnostic tests for the conditions for which screening is provided. [4]
- The WWWP only covers screening and diagnostic tests for part of a woman's reproductive system. It does not cover screening for ovarian cancer, for example.
- The screening and diagnostic tests, and frequency of tests, covered by the WWWP are not always consistent with current clinical recommendations and practice.
- Not even all of the screening and diagnostic tests consistent with current clinical recommendations and practice for the area of the WWWP's greatest emphasis (breast and cervical cancer) are covered by the WWWP.
- The screening and diagnostic tests covered by the WWWP sometimes do not include newer tests that are increasingly used by practitioners.
- The types of screening tests that will be covered by the WWWP vary depending upon the age of the woman and/or on her family history or current symptoms.

Because the WWWP only covers a limited number of selected screening and diagnostic tests, in some cases medical practitioners have to decide if they should conduct the tests they feel are necessary to evaluate the risks to a woman's health, when doing so may put the woman at financial risk for paying for the test/service or require the medical provider to forego reimbursement. For example, if a physician suspects a woman in the WWWP may be at high risk for a sexually transmitted disease, he or she cannot order screening tests because STD screening is not covered by WWWP.

The screening and diagnostic tests, test interpretation methods, and frequency of tests covered by the WWWP are not always consistent with current clinical recommendations and practice and not all of the screening and diagnostic tests consistent with current clinical recommendations and practice for the area of the WWWP's greatest emphasis (breast and cervical cancer) are covered by the WWWP. For example, although current medical practice guidelines[5] recommend mammograms for women starting at age 40 every 1 to 2 years, the WWWP funds mammograms for women under age 50 only if they have a family history of breast cancer, have symptoms or are otherwise at risk.

In addition to limitations associated with the specific tests covered by the WWWP, we found that the program does not always cover new technology for the screening and

diagnostic tests it does cover. For example Pap tests cannot be read using the newer, more expensive, but also frequently used "Thin Prep®" method. Current WWWP policy is to reimburse the provider for the cost of the standard (less expensive) Pap test. Thus the provider will not be fully reimbursed for this procedure. Because of this policy, some providers refuse to take WWWP clients and others are not fully reimbursed.

Because providers have a responsibility to offer treatment to women regardless of their ability to pay or source of payment, failing to cover the screening tests and diagnostic work and test interpretation methods that the providers routinely use in their practice creates a conflict for the provider. Some providers do not participate in the WWWP because of its reimbursement policies.

Some of the misunderstanding related to what the WWWP covers also stems from the fact that the program only covers tests for part of a woman's reproductive system. For example, the WWWP covers screening for breast and cervical but doesn't cover screening for ovarian cancer. Even for the types of cancer screening that is covered, the program only covers some of the follow-up diagnostic work that may be needed if a screening test result is positive. For example, there is a limit on the number of biopsies that will be covered for breast cancer. The program also limits the number of tests covered within a type of test. For example the WWWP currently covers one type of HPV test and only under specific conditions. [6]

We also found issues related to program policies for covering services based on the age of the woman. For example, as noted above, the program will reimburse for mammograms for women under age 50 only if the woman has a family history of breast cancer, symptoms, or is otherwise determined to be at risk of cancer.

Collectively, the limited procedures covered by the WWWP, misunderstandings about the program's ability to provide comprehensive services, and WWWP policies about which services are covered all increase the chances that a WWWP provider will order tests not covered by the WWWP.

Issues Related to Expanded Services Currently Covered

Issues identified related to the tests covered through the Expanded Component of the WWWP included questions as to why some tests were included when other more relevant or cost-effective tests were not and questions about the rationale for changes which have been made to the list of covered services.

Local coordinators and WWWP providers noted that some of the tests funded through the Expanded Component of the WWWP address areas such as risk for heart attack and stroke which are responsible for more deaths of women than breast and cervical cancer, but that other tests included are not highly prevalent diseases for the women served by the program. (MS for example usually is seen at younger ages.) They felt that since the program no longer provides reimbursement for bone density testing to detect osteoporosis, the program should not include osteoporosis as a covered service.

Others question why these tests are included when other areas of the woman's reproductive system are not screened (ovarian cancer for example) or when other relatively inexpensive basic screening tests that are very important for the aging woman such as thyroid or colon cancer screening are not covered.

Several of the persons we spoke to noted that diagnosis for some of the areas included such as MS are very difficult to do. They also questioned why other tests such as screening for depression or diabetes are done when the program provides no support for further diagnostic work or for treatment of these conditions.

The local coordinators and providers we spoke with generally did not support adding multiple sclerosis services and education to the WWWP. They noted that MS is a diagnosis of elimination and there are no specific screening tests for it, and that it typically appears in women younger than those targeted by the WWWP. They questioned how much impact could be made with the limited resources provided.

Overall we found that the tests covered under the Expanded Component are not explained by a clear goal such as addressing leading causes of death for women targeted by the WWWP, addressing women's reproductive health, or addressing the most cost-effective screening tests for targeted women's overall health and well being.

Role of Key Partners

Central Office

Central office staff is responsible for :

- public education;
- provider services including assisting in resolving billing issues, complying with extensive federal reporting requirements specific to the breast and cervical cancer early detection program specified in the federal Cancer Screening and Tracking (CaST) data system, and providing technical assistance; and
- overall program administration including managing contract arrangements.

We interviewed all of the WWWP Central Office staff and found that they strongly believe in the value of the WWWP. Overall, Central Office staff believe the program benefits women and works hard toward achieving the goals laid out for them by the CDC, the State of Wisconsin, and management. They should be commended for their commitment and dedication to the women of Wisconsin.

Central Office staff also shared some concerns related to program operations. They reported that they spend a large share of their time addressing billing issues at the expense of other areas such as program quality assurance, outreach, case management, and provider education. The also had concerns about communication within the office and to external partners, interrelationships among the different functions and responsibilities of central office staff, and data gathering/reporting.

Data gathering via the current forms was identified as an issue. The WWWP is a data driven program with goals that are contracted for between the program and the CDC. Because the current forms do not contain fields for some of the required data required, staff has to contact local coordinators for the information. An example of this is that a call must be made to a local coordinator to determine the type of cancer each and every time a woman is diagnosed with an invasive cancer. Adding a couple of fields to the forms would alleviate the need for the calls. We were told that the WWWP's priority has not been forms revisions, but that the program currently is planning to revise the enrollment and activity reporting forms to resolve these issues and to better meet CDC reporting requirements. However, the date for these revisions is currently unclear.

All parties that work in the WWWP (Central Office, Regional Office, local coordinators, and providers) report communication is a problem throughout the program. Specifically, Central Office staff state that, although this is a relatively small program, there is a lack of coordination and communication among the different program areas. The timeliness of the communication coming from the Central Office was another identified area of concern. Examples of local coordinators not knowing that the provider agreements were being extended and lack of information regarding the implementation of the Family Planning Waiver's clients being eligible for "Well Woman" Medicaid were given. The local coordinators were concerned about their role in the implementation of this aspect of "Well Woman" Medicaid. Central Office staff expressed a concern that they did not know the budget amount allocated in each area of the program. For example, they told us they did not know how much had been allocated for purposes such as outreach or training. This is a problem as staff lay out their workloads and attempt to plan. Central Office staff also identified a need to access specific information about the location and names of approved providers as another example of a communication breakdown. Currently, EDS holds all provider agreements and assures they are signed and returned. Staff indicated a need, not only for themselves but also for local coordinators, to have a comprehensive list that includes provider name (agency), sites (locations), fiscal contact, and clinical contact.

Staff expressed a need for more of an overall view of the direction of the program and how each area interconnects. As one staff member put it: "In order to achieve program outcomes with service delivery for targeted populations or report required data to CDC, we need to continue to strengthen the connections between service delivery, case management (including with [local] coordinators), quality assurance, professional development, public education/outreach, and data." A need for consistency across the program so staff are talking to their partners with "one voice" was a common theme during interviews. How Central Office staff handles billing exceptions was given as another example of this. Staff suggested developing internal policies and procedures in addition to updating the external Policy and Procedures Manual as possible solutions.

Regional Office

Five current Regional Office and one former Regional Office WWWP contacts were interviewed during the summer and fall of 2004. Two of the individuals interviewed were Public Health Nurses, and four were Public Health Educators. The WWWP provides funding for the positions of only two of these regional office contacts. This includes funding 50% of the position in the Northern Regional Office and about 5% of the position in the Western Regional Office.

The self-reported level of involvement regional office staff has with the Central Office of the WWWP, local coordinators, and health care providers varies. The Northern and Southern Region staff spend more time on WWWP activities, and are in closer contact with local coordinators and providers, than the other regional office contacts. The Western Region contact person is also involved and knowledgeable about the program. The WWWP contact in the Northeastern Region, as well as the current and former WWWP contacts in the Southeastern Region, report having limited knowledge of the program, and spend relatively little of their time on WWWP activities.

Several of the regional office contacts noted that the WWWP Central Office staff ask less of the regional office staff, and seek their input less often, than in the case of other public health programs with which they work. Even the regional contact that appears to have the greatest involvement in the WWWP, the Northern Region, reported there are fewer responsibilities related to the WWWP than for the Diabetes Control Program, which funds the remaining 50% of the position. The following table summarizes the comments and suggestions of the regional office staff.

Regional Office Staff Comments

	Number of Regional Office Staff Who Mentioned This
Comment or Concerns About the WWWP	
Spoke positively of local coordinators and their efforts to try to help women and make the program work.	6
Billing-related problems are one of the biggest issues.	6
Data quality and/or the lack of a case management system for local coordinators are a concern.	5
The Central Office is generally unpredictable in meeting the needs of local coordinators, as well as to requests or suggestions from coordinators or regional office staff.	5
Billing has improved in the past year.	4
Communication between the Central Office and local coordinators and providers is inconsistent.	4
The WWWP is needed; it provides valuable services to under served populations.	3
Local coordinators have a lot of things to do, but not much time; they often put in more time than funded for.	3
The expanded service component is a source of problems.	3
Local coordinators don't always know when a provider joins or leaves the WWWP network.	2
Conference calls and/or monthly updates are useful and well-received ways to keep local coordinators up-to-date on program issues.	2
Cited concerns about adding screening for multiple sclerosis.	2
Maintaining such a large provider network is difficult and a source of problems.	1
Suggested Changes or Improvements	
Hold annual statewide meetings for the local WWWP coordinators.	3
Have an advisory committee with diverse membership, in order to resolve problems and obtain input from multiple perspectives.	2
Provide more training for WWWP health care providers.	2
Put enrollment forms online.	2
Maintain a master list of WWWP providers.	1

Local Coordinators

According to the Wisconsin Well Woman Program's (WWWP) web site there are 63 local coordinators for the 72 Wisconsin counties and the City of Milwaukee and 10 tribal coordinators representing the 11 tribes. We interviewed coordinators representing approximately 24 counties. Without exception, the coordinators we spoke with believe strongly in the premise of the Well Woman Program and the benefits for women. They should be commended for their service to this population and dedication to the program.

The duties of the coordinators as outlined in the Policy and Procedures Manual include:

1. Eligibility Determination and Enrollment
2. Case Management
3. Develop and Maintain an Essential Treatment Plan
4. Provide Support
5. Billing and Reimbursement Assistance
6. Reporting
7. Outreach, Recruitment and Education

Although all of the coordinators with whom we spoke describe their jobs as including these duties, how much emphasis is put on each area differs greatly from coordinator to coordinator. Some coordinators spend more time on enrollment and case management, while others spend a great deal of time on billing issues. Some indicated not much time is spent on outreach, since their caseloads are at the number they can handle and the program promotes itself by word of mouth.

Many issues were brought up during our discussions with the local coordinators. Identified as issues and discussed in other sections of this document are billing issues; communication between Central Office, local coordinators, and providers; and misunderstandings about how and why certain extended services are included in the program.

A program requirement, which has generated confusion, is the Essential Treatment Plan. The Plan is described in the WWWP Policy and Procedures Manual as a plan that "identifies local, state or national resources that can assist the client in obtaining needed care and treatment." The Plan must be updated annually or more frequently as needed. The local coordinating agency must maintain the plan in its files and have it available for review by regional and central office WWWP staff. Some coordinators indicated that the Plan was no longer needed; some showed us a comprehensive, up-to-date binder with resources for clients; and yet others described it as an individual treatment plan for women whose screening was positive.

Several of the coordinators talked about communication issues. All of the coordinators we spoke with felt that the WWWP Monthly Update is a very valuable tool and appreciated this communication tool between them and Central Office. A number also felt that there was a need to have an opportunity for two-way face-to-face communication. They specifically cited the annual meeting as a valuable tool. With one exception, each local coordinator indicated they would like to see the WWWP annual meeting revitalized. The annual meeting was seen as a vehicle for networking, discussing what works and what doesn't in other areas of the state, training, and getting consistent current information from Central Office. Some local coordinators thought the meeting could be cut down to one day, with no overnights necessary. Even with an abbreviated schedule, coordinators noted that this meeting was very valuable to them.

When asked about areas in which the program might improve, coordinators had several suggestions. Some of these are summarized below:

- Consider establishing an Advisory Group, using the Family Planning Council as a model. In this model any partner is invited to attend. Attendees bring up, discuss and resolve program issues. The Family Planning Council has been very successful;
- Expand the "800" number for those who have limited English, specifically for Hmong and Spanish speakers; and
- The rollout of the MS component of the Expanded Services should be centralized. This would alleviate having to train all local coordinators and the confusion that

comes with that. Having the program centralized would mean that there would only be one statewide expert.

The most dramatic difference between the local coordinators with whom we spoke was how they handled case management. This subject is discussed in greater depth in the Case Management and Reporting Section of this report.

Consolidated Contract and Local Activity Reports

The WWWP funding allocation formula specifies the funding provided to public health department jurisdictions to manage the Well Woman program. The allocation formula includes two components, corresponding to the two sources of funding for the WWWP (federal and GPR).

- Federal -- The formula for this portion provides each jurisdiction a base amount; the balance is based upon the number of women in the jurisdiction who are 35-64 years old, with income at or below 185% of the federal poverty level.

- GPR -- For the GPR portion, allocations are based on the number of women ages 35-64, with an income at or below 185% of FPL (no base is provided).

The amounts determined by the formula are included in each local agency's contract. However, some agencies do not accept their allocation, in which case the allocation is contracted to a private agency or to an agency in another jurisdiction.

For calendar year 2004 grants to counties for the WWWP under the consolidated contract ranged from $7,582 (Pepin County) to $285,880 (Milwaukee City Health Department). The Milwaukee City Health Department grant included $131,384 for screening services. The average grant was $26,730 and the median was $17,895. Most of the grants were under $30,000. A few of the counties pooled their grants to form cooperative arrangements. A complete listing of the consolidated contract agencies and amounts is shown in the Appendix.

WWWP Consolidated Contract Grants to Counties	**Number of Grants**
Less than $10,000	6
$10,000 to $14,999	19
$15,000 to $19,999	18
$20,000 to $29,999	15
$30,000 to $39,999	6
$40,000 to $59,999	5
$60,000 or more.	4
Total	**73**

The Consolidated Contract process for the WWWP requires the negotiation of objectives that reflect desired outcomes or products, price, and risk. Performance expectations,

which are negotiated as part of the contract, typically have to do with the number of women screened. In some jurisdictions, the objectives may specify the number of women who belong to particular minority group(s), if relevant to the jurisdiction in question.

Agencies can choose from 4-5 template performance expectations, with standard language. Year 2004 Template Objectives for Wisconsin Well Woman Program were specified in six categories:

1. General Screening
2. New Clients
3. Breast Cancer Screening
4. Cervical Cancer Screening
5. Provider Recruitment
6. Partnerships.

Or, if it prefers, each agency can propose its own performance expectations, based on local needs. Then the Department responds, and the final expectations are negotiated, therefore they vary by jurisdiction.

A web-based, password-protected application, GAC (Grants and Contracts Application) is used to help manage the contract process. This system is used to monitor and document contracting decisions. Once performance expectations and risk profiles are negotiated, they are entered into the system. The system provides the details (specific performance objectives, recoupment levels, and incentives) for any WWWP agency.

Jurisdictions can re-negotiate their performance expectations if they need to, e.g. if unexpected staffing problems make it difficult to get the work done. DPH encourages agencies to try to do re-negotiation within the first three months of the year, rather than having it go on all year.

By January 31, agencies are supposed to provide evidence to the DPH regional office staff to demonstrate whether they have met their objectives for the year just ended. Regional offices are supposed to complete their review of agency performance by March, then notify agencies not meeting expectations of the amount to be recouped.

Recoupment -- Agencies not meeting their performance expectations are subject to recoupment, as specified in the contract. Agencies can appeal their recoupment. There were 3-4 appeals for WWWP this year.

Incentive funds -- Money that DPH recoups from agencies that don't meet performance expectations may be distributed as incentive payments among *eligible* agencies that *do* meet their performance expectations. Eligibility for incentives is written into the contract. Incentive payments are not mandatory or automatic -- if all agencies meet their performance expectations, no funds are recouped, so obviously there is no money for incentives. Also, incentives are something that DPH offers to agencies as a reward for excellent performance.

Regional offices are responsible for negotiating each agency's risk profile and deciding on the incentive to be awarded if recouped funds are available. Program staff may provide input into this process.

Agencies receiving incentive funds have until the end of the following calendar year to expend those funds. They must use it for purposes "within the bounds" of the contract. (E.g. incentive funds generated by the WWWP don't necessarily have to be spent on WWWP clients, but the funds must stay within the health department, and can't be put into the general fund.)

In interviews, an issue was raised concerning the data used to assess county performance under the consolidated contracts. It is not unusual for the county to come up with one number while Central Office's data shows a different number. At times the discrepancy is small, but occasionally it can be fairly large. Reconciliation can take an extraordinary amount of time to resolve. For example, one agency worked with staff from the central office for several months to assure the county's data showed in Madison reconciled with what her data system showed. Inability to reconcile the data can lead to monetary penalties against the agency.

There is an effort underway to streamline the collection of the outreach data used not only for federal reporting purposes but also for performance measures under the consolidated contracts. Some agencies report they set the numbers low, so that they are assured they can reach their goal. Others reported that the renegotiated process works well and they have used the process to modify their performance goals when necessary due to circumstances over which they had no control. Still others report that they had returned money to the State because extenuating circumstances occurred after the deadline for renegotiations, and they were required to return the money.

Provider Certification and Participation

Seventeen different provider types are eligible to participate in the WWWP. These include primary providers as well as ancillary providers such as registered nurses who may provide services when delegated and supervised by a WWWP physician. Providers are responsible for conducting screening and diagnostic tests and follow-up visits. To be certified as a WWWP provider, providers must meet the same standards for professional licensure and certification that are required for certification as a Wisconsin Medicaid provider, but they are not required to be Medicaid certified. There also are specific licensing and certification requirements for mammography providers, laboratories and outpatient hospitals. Local coordinators reported that most WWWP providers are Medicaid certified. An exception noted was the City of Milwaukee Health Department which serves many of the women enrolled in the WWWP in the City of Milwaukee.

The WWWP may discontinue a provider's participation if they fail to meet basic quality assurance standards or if they fail to conduct appropriate follow-up for clients. The local coordinators we spoke with had never had a WWWP provider who was discontinued.

In comparison to other states' NBCCED programs, Wisconsin's WWWP has an unusually large provider network. Currently there are over 1,000 providers. The large provider network has been developed to maximize women's access to the program. The goal is to have providers within a 50-mile radius of the women enrolled in the program. The large provider network also helps to ensure that "niche" providers serving special populations, such as Hispanic women, will be available. However, some coordinators told us that they had difficulty dealing with providers who only serve a few WWWP clients a year and thus are not familiar with the detailed requirements of the program and changes in program policies over time. Others noted that the large number of providers made it difficult to ensure that all providers are following current program guidelines and policies. Overall however, most of the coordinators we spoke with did not want to change the current WWWP provider network.

WWWP providers complete a "Provider Participation Agreement" form that is processed by EDS. A copy of this form appears in the Appendix. Local coordinators recruit providers in their county regions and help them complete the certification process. In the past, coordinators reported there were problems when it was time to re-new provider agreements. EDS mailed the Provider Participation Agreement forms to the providers but didn't send them to the correct people in the provider agencies. Local coordinators requested additional copies and contacted providers themselves in order to complete the provider agreement renewal process. Recently the WWWP central office decided that annual renewal of provider agreements would not be necessary. Provider certification was extended through June 29, 2006, instead of expiring September 29, 2004.

A suggestion from local coordinators was to publish a more detailed provider listing so they and WWWP clients would know the names and locations of all the WWWP providers in their areas. The current list just shows the corporate entity (i.e. Marshfield Clinic) which doesn't let the coordinator or the client know the location of providers in their local area.

Local coordinators told us that it is not uncommon for providers to refuse to offer services covered in the Expanded Component of the WWWP. One of the coordinators we interviewed reported that only 3 of the 29 WWWP providers in their area offered the Expanded Services component. Thus the coordinator did not tell clients being enrolled in the WWWP about the expanded services unless she was referring the client to one of these three providers. The primary reason cited for why many providers did not offer services in the Expanded Component was the lack of funding for treatment if problems were identified. Another reason cited was the lower reimbursement rates for services under the expanded program. Initially the WWWP paid the Medicaid rate for prevention office visits for established patients because Medicare did not cover this service and there was no Medicare rate to use. Subsequently the WWWP revised its rate and this no longer is a disincentive to providers offering services in the Expanded Component. Most of the coordinators we spoke with felt that providers should be able to limit the WWWP services they offered if they wished to do so.

One of the key provisions in the Provider Agreement is that the provider will not provide a service not covered by the WWWP to a client before informing the client that the service is not covered. However, in large clinic settings, business office staff maintains the Provider Agreement and medical practitioners may not be familiar with their responsibility under the agreement, including their responsibility to inform the WWWP client about services not covered by the program prior to providing them.

Some local coordinators suggested it would help if WWWP clients were given a WWWP card that they could show to the medical practitioner listing the type of services covered by the program and reminding the practitioner of his/her responsibility to inform the client before providing services not covered by the program. Some of the coordinators we spoke with gave WWWP clients printed material to share with the medical practitioner for this purpose.

Budget and Contract Arrangements

WWWP Budget

Following is a summary of the budget for the WWWP and a description of the main WWWP contracts. Main budget categories include the consolidated contract, payments to medical providers for screening and diagnostic tests, state operations, EDS claims and information processing, and GPR specified purpose funding.

WWWP Budget Summary FFY 2004

Consolidated contract	$1,951,290	33.80%
Screening service providers	$1,715,673	29.72%
State operations	$1,292,435	22.39%
EDS claims and information processing	$483,352	8.37%
GPR specified purpose funding	$190,700	3.30%
All other	$139,094	2.41%
	Total $5,772,544	**100.00%**

Notes: This budget summary was prepared using a detailed budget prepared by WWWP staff. The detailed budget appears in the Appendix.

Consolidated Contract

The consolidated contract, which is used to fund local WWWP coordinators and the services they provide, represented 34% of the program's 5.7 million dollar budget for 2004. Services provided by local coordinators include eligibility determination and enrollment; case management; development of Essential Treatment Plans; billing and reimbursement assistance; reporting; and outreach, recruitment and education. The actual amount allocated for these functions is slightly greater, however. In addition to the $1,951,290 amount shown for the consolidated contract, another $3,094 is provided to the Tribes for Expanded Services. (This $3,094 is currently included in the "All Other" budget category.)

Screening Service Providers
Payments to medical providers for screening and diagnostic services represented less than a third of the overall budget. However the actual total for providing screening and diagnostic services is also slightly higher because the $1,951,290 entry for the consolidated contract includes $131,384 for the pilot MBCAP project in Milwaukee. This is also used to reimburse screening providers. If this were added to the total shown for screening providers, in total, 32% of the budget would be allocated to reimbursing screening providers.

State Operations
Funding for state operations represents an additional 22% of the WWWP budget. "State Operations" includes federal funds used for personnel, fringe benefits, travel, equipment, and supplies ($951,490), federal funds used for office costs such as printing, rent, and administrative costs ($223,809), indirect charges ($47,036), DHFS internal contracts with BIS and BHI ($64,000), and federal funds for supplies ($6,100).

EDS Contract
Approximately 8% of the WWWP budget is allocated to the contract with EDS, the Department's fiscal agent for the WWWP. The contract with EDS for WWWP services is part of the Department's overall Medicaid contract with EDS.

EDS processes WWWP provider claims for reimbursement. It also processes WWWP enrollment forms, activity reporting forms and Provider Data sheets and Provider Agreement forms. After enrollment and activity reporting forms are processed by EDS and entered into a database, the database is sent to the WWWP central office staff. Corrections are then made to this database as needed, and the data is forwarded to the federal CDC twice a year to meet federal CDC reporting requirements related to the federal NBCCEDP.

Other responsibilities of EDS under the WWWP contract include responding to provider or central office questions related to individual claims and participating in and conducting training for WWWP local coordinators related to reimbursement and reporting issues. EDS also assists with projects on a periodic basis. Currently EDS is helping the Department develop a process for the electronic submission of enrollment and activity reporting forms.

GPR Specified Purpose Funding
The budget category "GPR Specified Purpose Funding" primarily reflects funding for the Expanded Component of the WWWP. The total shown excludes $422,600 from s. 255.06 (2) (a), which is used to support the consolidated contract. The $190,700 in the "GPR Specified Purpose Funding" budget category includes $30,500 for MS services for women. (In total, $60,000 was allocated for MS for a 2-year period.) Other expenditures in this category include media announcements and educational materials ($20,000), the mobile mammography van being used for outreach and education ($115,200), and training for rural colposcopic examinations and activities ($25,000).

All Other

The "All Other" budget category includes $84,000 for other external (non-EDS) contracts and consultants (described in the following section), $3,094 for the Tribes for Expanded Services, $22,000 for EPI Support and Technical Assistance, $5,000 for Education Outreach, and $25,000 for the Women's Health Conference.

Other Contract Arrangements

The WWWP also has contracts with a number of other organizations/individuals, which focus on outreach, public education, and professional education for the WWWP. The contracts for FFY 2004 are summarized in the following table.

WWWP Contracts FFY 2004

Contract	Amount
American Cancer Society (Outreach Native American Women)	$10,000
UW School of Nursing Web-based Professional Education	10,000
WI Women's Health Foundation Rural Health Programs (Recruit Rural Women ages 35-64)	10,000
UW Milwaukee. School of Nursing (Interdenominational B&C Ed & Outreach)	15,000
Local Health Departments' Public Education Campaign	25,000
Consultants	14,000
Total	**$84,000**

Note: The funds shown in this table are included in the "All Other" category in the preceding table.

Direct Services

Direct services to women are funded through a number of the WWWP budget categories and contracts. Budget categories funding direct services include the "Screening Service Provider" budget category as well as some of the funds budgeted in the "Consolidated Contract," "GPR Specified Services" and the "All Other" budget categories. Consolidated contract funding provides case management and assistance with billing in addition to other administrative functions such as eligibility determination, reporting and enrollment. Women also receive educational services funded by the "All Other" and the "GPR Specified Services" budget categories. The "All Other" budget category provides funding to the Tribes for Expanded Services which supports case management and assistance with billing issues for women. The "All Other" budget category provides educational services to women by funding the Women's Health Conference and by supporting contracts with local health departments to provide educational services.

Program Implementation

Outreach and Referrals

Outreach to encourage women to receive recommended breast and cervical cancer screening is a required component of the federal NCCEDP. Local coordinators are primarily responsible for outreach. Some coordinators reported that some of their providers also did outreach and that some providers also did "inreach," encouraging their existing clients to apply for the WWWP.

Coordinators reported that they were not able to do the amount of outreach needed to reach the women targeted by the program because their time was needed to manage their existing caseloads and complete required reporting to the state under the consolidated contract. They noted that caseloads were stable or increasing despite diminished outreach activities because the program was fairly well established.

Coordinators described a variety of activities they used to encourage women to enroll in the WWWP. Frequent activities were public service radio and TV promotions, distributing printed material to locations like grocery stores, printing advertisements in church bulletins, and distributing promotional gifts such as coffee mugs encouraging women to have regularly scheduled screenings. Some coordinators reported that they had employed staff to focus on outreach for special populations, such as minority women, and that this approach had been very successful.

Eligibility Determination and Enrollment

Local coordinators typically enroll women in the WWWP. A few providers also enroll women in the WWWP. Providers most likely to enroll women are hospitals and corporate clinics. When providers enroll women in the program, they send a copy of the enrollment form to the local coordinator as well as to EDS for processing.

We found that the procedures used to enroll women in the WWWP vary widely. Some coordinators request women to come to their office to complete the enrollment, using this as an opportunity to explain the program to the client and to gather information about the client and the type of screening she should receive. Most often however, enrollment is accomplished by phone and mail. The enrollment form is completed during a phone conversation and then mailed to the client for signature and returned by mail to the local coordinator who sends copies to EDS and to the providers the client is scheduled to see.

Coordinators reported that clarification was needed regarding the policies that should be followed to determine financial eligibility. This included identifying the procedures that should be used to verify income and to determine eligibility when unrelated individuals were living in the same household. They also wanted clarification about when women should be disenrolled from the program.

The coordinators we spoke to supported the requirement to re-enroll women in the program annually. They felt that this was warranted given mobility in the population and changes in women's status due to employment changes and marriages. They also felt that this provided an opportunity to remind the woman of screening tests they should have in the coming year.

Several local coordinators told us there was confusion related to the option for women to self-enroll in the program using the WWWP enrollment form that is on the Internet. This form tells the women to return the form to EDS, the WWWP fiscal agent. However, if the form is returned to EDS, local coordinators are not aware that women are considered "enrolled." Consequently they do not contact the women to set up appointments with providers or otherwise participate in the program. To rectify this situation, Central Office

WWWP staff added a first page to the form on the Internet that states: "Women interested in determining their eligibility for enrolling in the WWWP need to contact: WWWP Local Coordinating Agencies (this includes a link to the list of local providers).

Case Management and Reporting

In addition to enrolling and annually re-enrolling women in the program, local coordinators' case management responsibilities include:

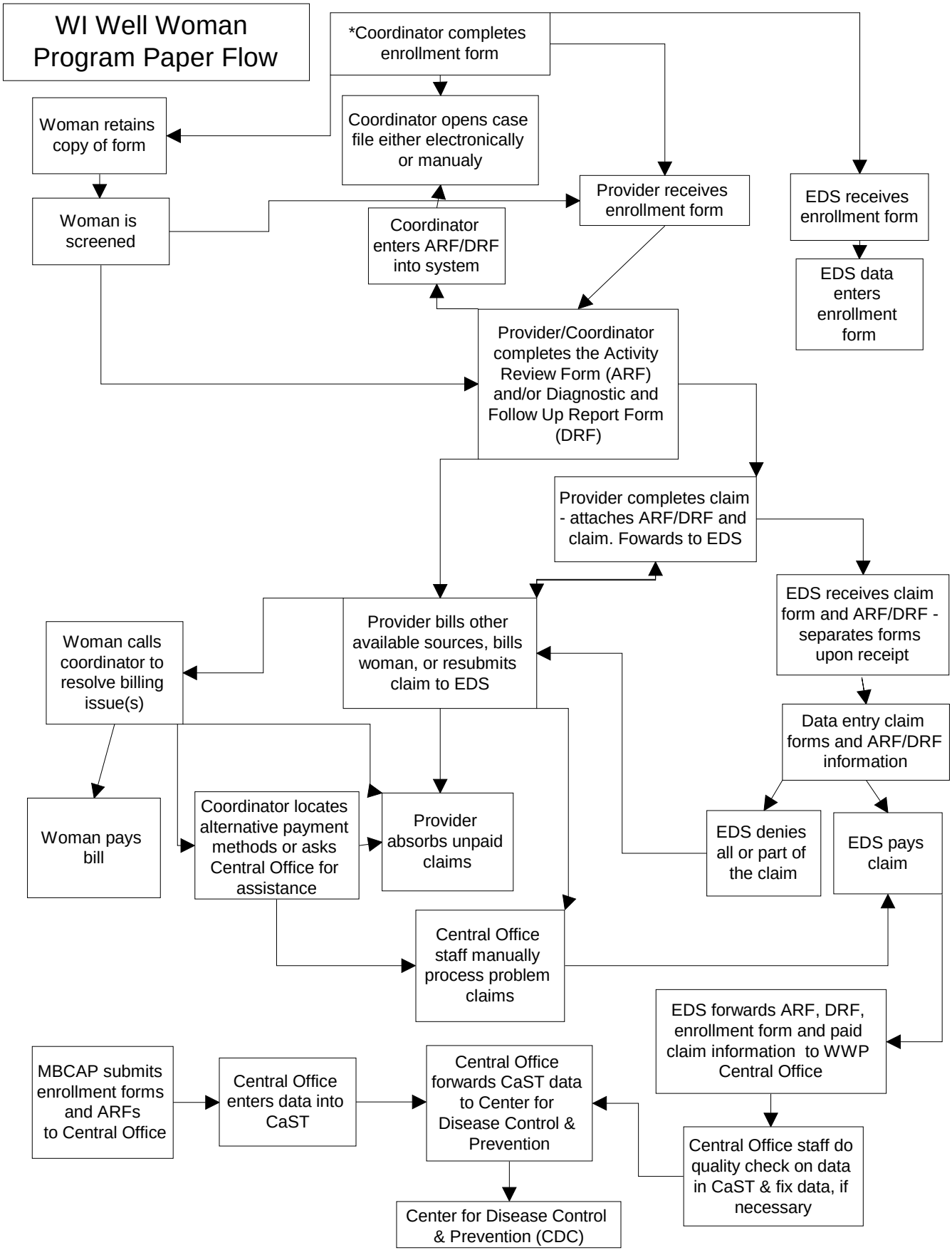
- maintaining a confidential database of enrolled clients and records (enrollment forms, reporting forms, progress notes, results of screening tests etc.) for each client,
- assisting women to set up appointments with providers for needed screening or diagnostic work,
- reminding women of the need for screening and diagnostic work or ensuring that the provider does so,
- helping women find services such as transportation or child care to enable them to go to scheduled appointments, and
- providing support and assistance in finding resources for treatment for women with abnormal results or diagnosed with cancer.

We found considerable variation in the approaches local coordinators used to maintain the information needed to implement their case management responsibilities for the WWWP. Some coordinators purchased and are using an Access data system, with reporting and an electronic version of the enrollment form. This system also is used to track screening and follow up work needed by individual women and to generate lists so coordinators can contact women about needed appointments or send reminders related to the need to re-enroll in the program each year. Other coordinators, typically those with relatively small WWWP caseloads, relied on paper records for the WWWP.

It was suggested by some of the people (local coordinators, providers and staff from Central Office) with whom we spoke that the Central Office explore developing a data system that could be used by all. Some local coordinators were content with using the Access data system independent of an interface with other coordinators' databases. If putting a statewide system in place is explored, local coordinators told us they wanted to be involved in the planning and development of the system. Providers also told us that any system developed should include the provision for them to continue to submit paper enrollment and activity reports so that they did not have to assume new responsibilities for data entry.

EDS and Central Office staff told us that procedures to allow for the electronic submission of enrollment and activity reports were being planned. This work, however, cannot go forward until revisions to the current enrollment and activity reports are completed. Thus the schedule for implementing electronic submission of enrollment and activity reports is not clear. Following is a summary of the current process for reporting and managing information for the WWWP.

WI Well Woman Program Paper Flow



*Enrollment process varies by coordiator. Please see narrative for additional information.

Coordination with Medicaid

The WWWP and Wisconsin's Family Planning Medicaid waiver both serve women ages 35-44. The programs cover some of the same services, but each program also offers services that the other does not. Women cannot be simultaneously enrolled in the WWWP and Wisconsin's Family Planning Medicaid waiver. This has created challenges for ensuring that women receive the services that will best meet their needs. Previously decisions about which program a woman would enroll in also had implications for her ability to receive Medicaid-funded health services if she was diagnosed with breast or cervical cancer.

Since January of 2002 women enrolled in WWWP diagnosed with breast or cervical cancer have been eligible for comprehensive health services through the Wisconsin "Well Woman" Medicaid program as long as they satisfy additional eligibility requirements (described below). Women enrolled in Wisconsin's Well Woman Medicaid program are eligible to receive the full range of Medicaid benefits from Medicaid-certified providers, including treatment for cancer and contraceptive-related services.[7]

Subsequently in July of 2004, women in Wisconsin's Family Planning Medicaid waiver diagnosed with breast and cervical cancer also became eligible for comprehensive health services through the Wisconsin "Well Women" Medicaid program as long as they satisfied the additional eligibility requirements. Previously women diagnosed with breast or cervical cancer could only get comprehensive health services through Wisconsin's "Well Women" Medicaid program if the cancer had been diagnosed when the woman was enrolled in the WWWP.[8]

Local WWWP coordinators shared frustration related to the complexity of the program policies they needed to work with and with the communication they received related to coordinating the WWWP with Medicaid. However, they also felt that recent policy changes whereby WWWP and Family Planning Medicaid waiver clients diagnosed with breast and cervical cancer could access comprehensive medical services provided by Wisconsin's Medicaid program were a tremendous benefit for these women.

Well Woman Medicaid.--A major limitation to the WWWP in the past was the lack of funding for treatment if a woman was diagnosed with breast or cervical cancer. In October 2000 the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (PL 106-354) gave states the option to provide medical assistance through Medicaid to eligible women who were screened for and found to have breast or cervical cancer, including pre-cancerous conditions, through the NBCCEDP.[9] Wisconsin adopted this Medicaid program effective January 1, 2002.[10] To be eligible for Wisconsin Well Woman Medicaid, a woman enrolled in the WWWP must meet all of the following criteria:

- Meet the income and other requirements for the WWWP
- Be at least 35, but under 65, years of age.
- Be a resident of Wisconsin
- Be a citizen or qualifying alien
- Provide a Social Security number or apply for one

- Not eligible for private or public health care coverage (this includes Medicaid or any of its subprograms, group health plans, health insurance, Medicare Parts A or B, veterans' benefits/CHAMPUS, HIRSP, federal employee health plan, Peace Corps health plans, or other public health plans.)
- Have been screened for breast or cervical cancer by the WWWP
- Have a diagnosis of breast or cervical cancer, or precancerous condition of the cervix, as identified by the screener
- Require treatment for the breast or cervical cancer, or a precancerous condition of the cervix, as identified by the screener. [11]

Through presumptive eligibility, WWWP recipients diagnosed with breast or cervical cancer have immediate access to Medicaid-covered services for a month. To continue to receive Medicaid services, they must apply for ongoing eligibility at the local county/tribal social or human services agency. Women can continue to be eligible for the Wisconsin Well Woman Medicaid program until they no longer need treatment for breast or cervical cancer or otherwise become ineligible for Well Woman Medicaid (i.e. for reasons such as moving out of state, turning 65 or obtaining health insurance or another type of Medicaid). Some local WWWP coordinators report that they continue to provide case management and follow-along services for WWWP clients after they are enrolled in the Well Woman Medicaid program. Other coordinators report that when a WWWP client enrolls in Well Woman Medicaid, they keep the case in a pending status until the woman is no longer eligible for the Wisconsin Well Woman Medicaid program.

Family Planning Medicaid Waiver.—Wisconsin's Family Planning Medicaid waiver started in January of 2003. It serves women ages 15 through 44. Wisconsin's Family Planning Medicaid waiver is similar to the WWWP in that it only provides coverage for selected services. The Family Planning Medicaid waiver provides screening and some diagnostic tests related to cervical cancer, but it does not provide mammograms or diagnostic tests related to breast cancer. The Family Planning Medicaid waiver also provides contraceptive services as well as other services such as tests and treatment for Sexually Transmitted Diseases, which the WWWP does not.[12] Women receiving services from the Family Planning Medicaid waiver are not eligible to also receive services from the WWWP.

Local coordinators report they face challenges giving women ages 35-44 advice about which program would best meet their needs. For example, the WWWP serves women starting at age 35 and targets women ages 50 through 64 for breast cancer screening. However women under age 50 who have symptoms or risk factors for breast cancer may also be eligible to have mammograms through the WWWP. Consequently if a woman age 35-44 has a history of breast cancer, local WWWP coordinators may recommend that she enroll in the WWWP so they can get the breast cancer screening. Women without a family history or risk factors for cancer who want to have coverage for contraceptive services will be referred to the Family Planning Medicaid waiver. If a woman age 35-44 enrolled in the Family Planning Medicaid waiver is diagnosed with cancer following breast or cervical cancer screening provided through the Family Planning Medicaid waiver, she may also be able to receive Medicaid-funded medical services through the

Wisconsin Well Woman Medicaid program. A policy change effective July 2004 allows women participating in Wisconsin's Family Planning Medicaid waiver who are diagnosed with breast or cervical cancer to become eligible for the Wisconsin Well Woman Medicaid program as long as they satisfy the additional eligibility requirements.[13]

The number of women receiving Medicaid-funded health services through the Wisconsin Well Woman Medicaid program grew steadily since the first women were served in January of 2002. Wisconsin's Family Planning Medicaid waiver has seen even greater caseload increases since waiver services first became available in January 2003. This suggests that issues related to coordinating the WWWP with Medicaid will become increasingly important and that local WWWP coordinators will need to keep informed about Family Planning Medicaid waiver and Wisconsin's Well Woman Medicaid program policies.

Medicaid Program Caseloads

Date	Well Woman Medicaid *	Family Planning Medicaid Waiver
Jan 02	10	
Feb 02	19	
March 02	32	
April 02	43	
May 02	54	
June 02	62	
July 02	62	
Aug 02	73	
Sept 02	75	
Oct 02	82	
Nov 02	90	
Dec 02	101	
Jan 03	98	3,328
Feb 03	106	7,952
March 03	107	12,833
April 03	103	16,685
May 03	111	20,466
June 03	118	23,338
July 03	123	25,896
Aug 03	123	28,985
Sept 03	124	31,158
Oct 03	141	34,019
Nov 03	144	35,868
Dec 03	151	37,152
Jan 04	157	39,060
Feb 04	158	39,895
March 04	168	40,157
April 04	177	40,775
May 04	184	41,458
June 04	188	42,121
July 04	199	43,952
Aug 04	206	44,783
Sept 04	208	45,652

Source: DHCF, Monthly Medicaid Enrollment, Eligible Individuals on MMIS *Includes women diagnosed with breast and cervical cancer, either through the WWWP or (since July 2004) while enrolled in the Family Planning Medicaid waiver.

Reimbursement and Billing Issues

The primary issues we found related to provider reimbursement were frustration with the requirement to submit activity reports as a condition of payment, delays in reimbursement, a relatively high incidence of denied claims, and instances in which women have been billed for services received through the WWWP.

The Process

EDS, the state's contracted fiscal agent, reimburses health practitioners providing services to women enrolled in the WWWP.[14] Provider reimbursement is contingent upon the provider submitting WWWP enrollment and required activity reporting forms (ARFs and DRFs) describing the services provided and follow-up for identified problems as well as the standard claims for medical services. A completed Provider Agreement form is also required for EDS to pay claims.

Providers have the option to submit claims electronically; however, they still must submit paper enrollment and activity reporting forms. Also, amended claims for "multiple units" for eligible procedures still must be submitted as paper claims because these are processed manually by the WWWP claims system. Currently few providers use the option of submitting claims electronically both because they still need to submit paper enrollment and activity reports and because the procedures involved to submit electronic claims are unique to the WWWP. Thus it is not cost-effective for providers to use the electronic claim submittal system. EDS reports that recently providers were given the option to submit claims electronically via the same procedure used to submit Medicaid claims. They expect that more providers may use this procedure because they are already familiar with it. The WWWP currently is also developing procedures to make it possible for providers to submit enrollment and activity reporting forms electronically. This process would likely reduce the number of denied claims because it would include edits to prevent incomplete reports and claims with invalid procedure codes.

Currently when EDS receives WWWP enrollment, activity reporting or claims forms, the individual forms are separated by type for processing. Enrollment forms are used to create a master enrollment file. EDS reports that this file is required to validate client eligibility before paying for services and to facilitate matching claims with activity reports. However EDS also reports receiving an average of 4-5 enrollment forms per woman. This happens because local coordinating agencies generally submit the original enrollment form, and providers submit copies of enrollment forms because the providers want to make sure that EDS has the enrollment on file. In some cases a provider can enroll clients, and they know they need an enrollment form on file to be paid. This leads to an increased workload for processing by EDS. EDS edits incoming activity report forms and matches them with enrollment and claim forms. Following is a summary of the action EDS takes if incomplete information is received.

How EDS Treats Incomplete Forms

Type of Form Received	Action if Incomplete*
Enrollment form-submitted by local coordinator and/or by provider(s) (depending upon who enrolled the client)	EDS sends letter to the local coordinator identifying the missing data elements. No claims will be processed until required information received.
Reporting forms (ARFs and DRFs, 5 separate forms) – submitted by provider(s)	EDS sends a letter identifying the missing data elements to the provider. If the missing information is not received in the 90-day grace period, the claim will be denied with the reason "no activity report on file."
Claim form- submitted by provider(s)	A letter is sent to the provider identifying the information that is missing. The claim stays in pending status for 90 days. If the required information is not received in that time, the claim will be denied.

* Note: Only some of the data on each of these forms is actually required by EDS to process a claim. In this table the term "Incomplete" refers to a form missing a required data element.

Providers noted issues related to the type of communication used to identify problems with enrollment, activity or claims submitted to EDS. They especially objected to the letter telling them that no reporting form was on file when a report had been submitted but was incomplete. Providers and coordinators also voiced frustration with delayed processing time with certain types of claims. Overall however, most of the persons we interviewed reported that the processing time and overall claims processing had improved recently and they appreciated the one-to-one assistance they received from EDS and central office staff related to billing issues.

Denied Claims

A single claim from a provider typically includes charges for a number of individual services or procedures. Each of these services or procedures is described by a code referred to as a CPT code. The charges for the individual services or procedures are referred to as "claim details." An analysis of claims from April of 2002 (when the federal NBCCEDP Breast and Cervical Cancer program was merged with the state-funded Wisconsin Healthy Woman Program) through August of 2004 shows a denial rate of 33.8% for claim details. This rate is slightly higher than that for other programs. EDS reports that the denial rate for HIRSP claims is around 29-30%, and for Medicaid it is approximately 28%.

Twenty-three codes are used to describe the reasons for denying WWWP claims. An analysis of denied claims for the period April 2002 through August 2004 shows that the primary reason EDS denies claims is, "Services not covered by WWWP (e.g., emerging technologies, treatment, inpatient, other non-covered conditions."[15] This is reason code 8: "Claim detail denied for invalid CPT, invalid CPT/modifier combination, or invalid type of quantity billed. Billed **procedure not covered** by WWWP." By itself, this reason code accounts for approximately 74% of the claim details that are denied. A second reason for denying claims very similar to this is reason 10: "Claim denied for invalid diagnosis code or diagnosis code/CPT combination. The **diagnosis is not covered** by WWWP." This reason code accounts for another 2.5% of the total claim details denied. (The WWWP stopped denying claims for invalid diagnosis code in the fall of 2002.)

The high incidence of claim details denied because the service or procedure is not covered by the WWWP occurs because the program only covers selected tests and procedures and test interpretation methods and also because there are misunderstandings about which services and procedures are actually covered by the WWWP.

Other factors also contribute to the high incidence of claim details denied for reason code 08. EDS notes that the large volume of claims received for procedures and diagnoses not covered by the program occurs because providers typically bill all possible payers for services provided. Then they see who pays for what. This reduces the length of time they have to wait for reimbursement. If a claim is denied by the WWWP, the provider will then either bill the woman directly or re-bill other insurance if there is any. A second factor contributing to the high incidence of claims denied because the procedure is not covered was a problem processing breast biopsy claims. EDS reports that the WWWP payment system was not developed to handle multiple biopsy claims so they had to develop a manual work around. They now have an in-house manual process to pull claims needing special handling. (Previously these claims were being denied for "invalid quantity billed.")

The second main reason for denying claims is **duplicate claims**. EDS receives duplicate claims because providers typically submit a second claim if they are not paid within a specified number of days (typically between 10 and 45 days). The analysis of denial reason codes showed that duplicate claims accounted for approximately 14% of the denied claims. This reflects problems in expediting payment once a claim is submitted.

Other key reasons for denying claims are related to the **enrollment and activity reporting requirements** of the WWW. Enrollment and reporting requirements were directly responsible for less than 10% of the claim detail denials. Reason codes related to reporting include:

- Reason Code 13 "Claim denied for no client enrollment form on file." (1.4% of the total)
- Reason Code 14 "Claim detail denied for no matching reporting form on file." (6.9% of the total)

Collectively the other 7 reasons noted accounted for less than 2% of the denials.

Reasons for Denying WWWP Claim Details (April 2002-August 2004)

Reason	#	%
08. Claim detail denied for invalid CPT, invalid CPT/modifier combination, or invalid type of quantity billed. Billed procedure not covered by WWWP.	171,945	73.5
06. Claim detail denied as duplicate. CPT code and service date for recipient is identical to another claim detail on file for provider on claim.	33,365	14.3
14. Claim detail denied for no matching reporting form on file.	16,049	6.9
10. Claim denied for invalid Diagnosis code or diagnosis code/CPT combination. The diagnosis is not covered by WWWP.	5,758	2.5
13. Claim denied for no client enrollment form on file.	3,359	1.4
15. Claim detail denied due to required information missing on the claim.	1,432	0.6
09. Claim detail denied. CPT or CPT/modifier combination is not valid on this date of service.	1,319	0.5
12. Claim denied for no provider agreement on file or not certified for date of service.	397	0.2
04. Claim has been adjusted due to previous overpayment. Money will be recouped from your account.	253	0.1
20. Claim denied for future date of service.	84	<0.1
23. Detail denied. To date of service precedes From date of service.	30	<0.1
11. Claim denied. The Diagnosis code is not valid on this date of service.	21	<0.1
Total	234,012	100%

Women Billed For Services

An unintended outcome of the WWWP has been instances in which women were billed for services received through the program.

Local program coordinators told us that they attempt to find alternative sources of funds to pay for services if women are billed, but such resources are limited. One alternative source of funding mentioned by a number of the coordinators we spoke with was a "PIN fund." This statewide fund is supported by fundraising activities such as selling donated quilts. It has been used to pay for services women in the WWWP program receive that are not covered by the program such as bone density tests or digital mammograms. This fund also has limited resources. The average monthly payment from January through June of 2004 was under $500 and just 36 women received funding. [16]

We found a number of factors that contributed to women being billed for services received through the WWWP. First, providers perform/order tests or work not covered by the program. This occurs for a variety of reasons including: the fine distinctions that need to be made to follow program guidelines regarding which tests/work will be covered, changes in program guidelines over time, failure to notify providers that women are in the WWWP, failure to give information about covered services directly to the medical provider, and turnover in the providers in the program.

In other cases, women are billed for services that are covered by the program due to WWWP reimbursement issues. Thus women have been billed for services because the program does not pay claims soon enough to prevent medical providers from turning bills over to collection agencies in accordance with their standard business practices.

We also found cases in which women were billed for services because the WWWP reimbursement policy differed from other major payers such as Medicare. One instance reported to us by some coordinators was the Medicare-approved practice of allowing

providers to bill for both Preventive Medicine (routine screening) and Evaluation/ Management (problem) office visits on the same day of service. Medicare allows this if the problem identified during the Preventive Medicine exam requires "significant additional work." However the WWWP will not reimburse for both a preventive and a problem-focused visit on the same day.[17] Consequently when the claim is denied payment by the WWWP, some providers seek reimbursement from the women. This situation is particularly difficult to prevent because there is no clear cut way to predetermine the type of health care service the medical practitioner will initiate during an office visit, and also because the client may not even realize that she is receiving "problem focused" care in addition to a routine prevention office visit.

Central Office Efforts to Alleviate Billing Problems

Central office staff have taken a number of actions to alleviate billing problems. These include:

- Revising WWWP reimbursement policies. For example, starting June of 2004, the WWWP instituted a policy whereby the "90 modifier" on claims could be ignored. Prior to this, the inclusion of this modifier prevented EDS from paying the claim. Providers reported that central office took extended periods of time to change policies to alleviate billing problems, noting that the change related to the 90 modifier took over 6 months to complete even when a high volume of claims were being denied due to this problem.
- Revising WWWP reporting forms. For example, starting this November the Expanded Services Report Form 4730 will no longer require that providers put their provider number on the form. Requiring the provider number has caused a number of denied claims.[18]
- Additional changes to the reporting forms are also planned to align the forms more closely with current medical practice.
- Providing more written clarification on current policies. Central office staff has increased their efforts to issue written clarification of reimbursement policies. An example of this is an expanded section in the WWWP monthly updates. This communication has been favorably received by local coordinators and providers.
- Seeking input from the Wisconsin Medical Society regarding billing practice.

Central Office staff has also adopted manual work-arounds to alleviate billing problems. For example, central office staff routinely changes the CPT codes used to bill for selected procedures or from certain providers so providers can be reimbursed. However this practice is time consuming and fosters confusion regarding what will and will not be reimbursed by the program.

The need for such manual work-arounds could be diminished if the current WWWP reporting forms are updated to be consistent with changes in WWWP policies regarding services covered. Reporting forms have not been changed for 3 years, but the services covered are updated annually.

The need for manual work-arounds could also be reduced if additional changes were made to WWWP reimbursement policies. A current reimbursement issue for the program is its policy of paying for a less expensive service when a more expensive service not covered by the program has actually been provided. For example, if a digital mammogram is provided and billed the provider will be reimbursed at the rate for the comparable conventional mammogram.[19] And if the "Thin Prep®" method is used for a Pap test, the provider will be reimbursed at the conventional standard Pap test rate.

There are a number of problems with this policy. Billing staff reported that they were uncomfortable billing for a different procedure than the one that was actually provided. They also noted that this practice resulted in inconsistent patient records because the code on the billing record differed from the correct code in the patient's chart. This practice also requires providers to absorb the cost for the non-reimbursed portion of the service or procedure. If the provider uses the correct code to bill for the service, the claim will be denied. This, in turn, may result in a provider billing the woman directly at the higher private pay rate for the service when the claim is denied by EDS.

Program Impact

Achievement of NBCCEDP Program Goals

The Wisconsin Well Woman Program submits an annual funding request to the Centers for Disease Control in order to receive funds under the National Breast and Cervical Cancer Prevention Program. As part of the grant application process, the WWWP submits an interim progress report describing its activities related to screening Wisconsin women for breast cancer and cervical cancer. The grant application also includes a work plan for the upcoming period for which funding is requested. Program objectives and performance targets related to a number of program components are negotiated with the CDC. Ten program components are included in the work plans and progress reports:

A. Management
B. Screening
C. Tracking, Referral and Follow Up
D. Case Management
E. Quality Assurance and Improvement
F. Professional Education
G. Public Education and Outreach
H. Coalitions and Partnerships
I. Surveillance
J. Evaluation

The work plans and progress reports include several objectives related to each of the program components listed above. In order to summarize and assess the WWWP's progress in meeting its performance objectives, interim WWWP progress reports for two recent funding periods were reviewed:

- Progress as of February 13, 2003 for FY 2002 (June 30, 2002 through June 29, 2003)
- Progress as of February 16, 2004 for FY 2003 (June 30, 2003 through June 29, 2004)

Summary of Progress in Meeting Objectives

In order to summarize and assess the WWWP's progress in meeting these objectives, each program objective was assigned to one of four categories depending on whether or not the performance objective had been met, or whether it appeared the objective would be met by the end of the funding period. The numbers in the cells in the table below refer to the specific objectives in the progress reports. A copy of the individual objectives from these progress reports appears in the appendix to this report.

Performance Category	**Accomplished**	**In Progress - On Target**	**In Progress - Not on Target**	**Deferred, re-scheduled, no activity/no progress**
Definition of Performance Categories	The objective was met.	Activity ongoing; objective appeared likely to be met.	Activity ongoing, but objective not likely to be met.	The objective has not yet been met.
FY 2002: 6/30/02 - 6/29/03				
A. Management	1, 5	2		3, 4
B. Screening			1, 2, 3, 4, 5	6
C. Tracking, Referral and Follow Up		1, 3, 4, 5	2	
D. Case Management				1, 2, 3, 4, 5
E. Quality Assurance and Improvement	5	4, 6, 7	1, 2, 3	
F. Professional Education	1, 2	3		
G. Public Education and Outreach		1, 2		3
H. Coalitions and Partnerships	3	1		2
I. Surveillance	2	1		3
J. Evaluation				
FY 2003: 6/30/03 - 6/29/04				
A. Management	1	3		2, 4, 5
B. Screening		1	2, 3, 4, 5	
C. Tracking, Referral and Follow Up			1, 2, 3, 4, 5, 6, 7, 8	9
D. Case Management				1, 2, 3, 4
E. Quality Assurance and Improvement	4	3, 5	1, 2	
F. Professional Education	1, 2	3		
G. Public Education and Outreach		1, 2, 3		
H. Coalitions and Partnerships		1, 3		2
I. Surveillance		1		2
J. Evaluation		1, 3		2

Using this method of describing the program's performance, the WWWP generally seems to be meeting its performance objectives in the areas of Professional Education, Public Education and Outreach, and Coalitions and Partnerships. One reason for this may be that in these areas, the program has not experienced staff vacancies causing disruptions and delays of the work.

Other observations based on the review of the WWWP progress reports:

Management -- HIPAA implementation interrupted and delayed activity in this component during FY 2002. Other program management activities that were not completed during the time periods examined included linking the WWWP database with the Cancer Registry, and developing a provider list service.

Screening -- In general, the number of women screened tends to be somewhat lower than the targets, although this was better in FY 2003 than in FY 2002 (when HIPAA was being implemented). The WWWP appears to have particular difficulty in reaching women who are in priority (i.e. minority) populations, as well as those who were never or rarely screened for cervical cancer.

The number of women who are screened by the WWWP has been declining in recent years from 8,840 in FY 2001-02 to 7,011 in 2002-03 with an expectation of 7,000 in FY 2004-05. (This includes the number of women who received at least one funded screening service, i.e. mammogram, clinical breast exam or Pap smear.[20] The CDC estimates that approximately 20-21% of eligible women aged 50 to 64 years receive Pap tests and mammograms through the NBCCEDP.[21]

Tracking, Referral and Follow Up -- The WWWP also appears to have some difficulty in meeting objectives related to obtaining timely screening results, diagnosis and treatment, and providing enrollees with timely and appropriate follow up.

This is admittedly a limited method of assessing the extent to which the WWWP has met its objectives. For example, a simple categorization of progress toward objectives does not take into account the reasons or explanations for failure to meet specific objectives. In some cases circumstances beyond the control of the WWWP, such as staff vacancies, contributed to an inability to meet certain objectives.

In addition, this method assumes that all performance objectives are equal in importance, but that may not be the case. This approach also does not consider the possibility that some objectives may be contingent upon the completion of others. Failing to meet some objectives may mean that objectives contingent upon them also will not be met.

Finally, in the areas of Screening, Tracking and Follow Up, and Quality Assurance and Improvement, some of the results cited in the progress reports probably reflect the difficulty of measuring performance in a relatively small program that has few cases during the reporting period. Where the number of cases is small, it only takes a few more or less to change percentages dramatically.

Achievement of Expanded Services Goals

Information providers submit to EDS on activity reports that describe the expanded services provided to women is not summarized. Some local coordinators include

objectives related to the Expanded Component in their consolidated contracts, but this is not uniform across the state. Thus it would not be valid to draw conclusions about the effectiveness of the Expanded Component based upon the limited information included in the consolidated contract GAC reporting system.

Recommendations

Based on the information we gathered from local coordinators, Department staff and WWWP providers, we offer a number of recommendations for program improvement. These include suggestions to re-focus the WWWP so that it does a better job of providing breast and cervical cancer screening to the women targeted by the program. They also involve re-examining the purpose of the Expanded Component so it can better support the goal of providing breast and cervical cancer screening and priority health screenings to women who would not otherwise receive these services. Adopting these recommendations should make it easier to explain the WWWP to women and providers, and reduce some of the administrative work related to the program's current complex policies. They also should reduce the likelihood that women will be billed for services received through the program or that providers will not be reimbursed for services provided to women in the WWWP.

1. **Services Covered by the WWWP**

- **Update List of Services Covered More Often**
  One of our key recommendations is to update the list of services covered by Wisconsin's WWWP more frequently. We recommend that after CDC adds a service to the list of services that can be reimbursed by the NBCCEDP, Wisconsin's list also is updated so Wisconsin providers are able to be reimbursed for these services as soon as possible. In order to implement this recommendation, it may be necessary to increase the number of times the WWWP Clinical Issues Workgroup meets during the year.

- **Provide Better Coverage For Breast And Cervical Cancer**
  DPH and the WWWP Clinical Issues Workgroup should review the breast and cervical cancer services currently covered by the WWWP to explore options for covering services that are more consistent with current medical practice guidelines. Consideration should also be given to making a more comprehensive commitment to screening and diagnosis of breast and cervical cancer so that tests recommended for the women served by the program are in fact covered by the program. If necessary, these actions may involve re-allocating funding currently provided in the Expanded Component.

- **Simplify Policies on Services Covered**
  Efforts should be made to simplify the policies related to covered services as much as possible because this will help to reduce misunderstandings that lead to practitioners ordering tests and procedures not covered by the program.

- **Communicate Services Covered and Program Limitations**
  We also recommend that the program provide women with a wallet size card listing the procedures covered by the program. The card also should remind the provider of his/her responsibility to notify women before providing services not covered by the program. This will help to increase the chances that providers will know which of their patients are enrolled in the WWWP. The program may also consider changing the name of the program to the "Wisconsin Well Woman **Screening** Program." This will help to clarify the purpose and limitations of the program.

- **Initiate additional efforts to ensure that medical practitioners --especially those in large clinic or hospital settings --are aware of the contents of the WWWP Provider Agreements.** This will better ensure that women are informed before they receive services not covered by the program. These efforts may especially be called for given that the agreements are not being renewed on an annual basis. This increases the probability that medical practitioners will not be familiar with them.

2. The Expanded Component

We recommend that options be explored to change state statues to allow the Expanded Component to be refocused so that it can better support Breast and Cervical Cancer screening. Options should be explored for using state funding to fill gaps that lead to billing women and not reimbursing providers fully or at all. As one coordinator suggested, "Focus on breast and cervical cancer and do it well."

We agree with a coordinator's observation that there is a need to clarify whether the WWWP is a comprehensive health care program or a screening program for a limited number of conditions. Currently the program seems to be trying to do both and that is causing problems.

As an initial step in re-focusing the Expanded Component, we recommend the WWWP central office staff summarize information from the Provider Participation Agreements indicating which screening components providers offer. The state could then analyze this information to assess the extent to which the Expanded Services component is really available to clients in the WWWP throughout the state.

We also suggest that the list of screenings currently covered by the Expanded Component be reviewed to focus on a few priority areas. The WWWP should consider revising the services covered under the Expanded Component so that in addition to supporting breast and cervical cancer screening, covered services focus on areas of high risk (cardiovascular health or diabetes) for the women of the ages targeted by the WWWP. The program and its Clinical Issues Group should also consider options to screen for ovarian cancer to coordinate with other areas of reproductive health addressed.

Related to this recommendation we suggest exploring options to modify the program's current use of GPR funds in two areas:

1) Funds currently allocated for the mobile mammography van in Milwaukee ($115,200) are being used for public education and outreach but not to provide mammograms as originally intended.
2) The $422,600 currently being used for the consolidated contract was originally provided to fund mammograms for women over age 40, making it possible to serve women under age 50.

In view of the limited resources available for the Expanded Services MS Component, it is recommended that implementation be accomplished by working with the MS Society and the five regional MS centers with one program expert located in the Central Office.

After decisions have been made about revising the Expanded Component, it is recommended that consideration be given to **reducing the size of the current provider network.** A smaller provider network would make it significantly easier to operate the WWWP and ensure that all providers are aware of, and able to follow, current program policies and guidelines.

3. Communication and Coordination Among Various Parties

In regard to local coordinators, it is recommended Central Office:

- Reinstate the annual meeting. If it is determined that reinstatement is too costly in terms of staff and financial resources, consideration should be given to using the Division's new Mediasite technology. Although the person-to-person networking aspect of a gathering would not be realized, all parties would hear a consistent message from the Central Office. At this time, there are no monetary costs associated with the use of Mediasite.
- Continue to produce the Monthly Updates.
- Continue opening the lines of communications between the local coordinators/Regional Office/Central Office by having Central Office attend the regional coordinator's meetings and participating in the telephone conferences.

In regard to all partners, it is recommended Central Office:

- Consider the formation of a WWWP Advisory Group based on the Family Planning Council model. This Advisory Group would be most helpful in working with Central Office staff in formatting a strategic direction for the program, identifying needed updates to the Policy and Procedures Manual, and other needed program changes.
- Issue a detailed provider list that includes the providers' names, locations, billing contact and medical contact person.

In regard to the Regional Offices, it is recommended Central Office:

Reconsider the role of the Regional Offices in the Well Woman Program. The WWWP is a small complex program, where the majority of the technical assistance is sought from the Central Office staff. The primary function of the Regional Office has been

coordination. Consideration should be given to consolidating the resources dedicated to the Regional Offices into staff located in the Central Office.

4. Reporting Requirements

It is recommended, along with its partners, the WWWP explore the development of a statewide web-based data system. In conjunction with that exploration, it is recommended the WWWP explore the inclusion of the enterprise service bus technology currently being implemented by the Division of Electronic Technology in the Department of Administration. (More information on this initiative can be seen at http://operations.state.wi.us/asx/WhatsHappening/INDEX_051004.asp)

The benefits of a statewide web-based system are many. This is especially true if an interface between the providers' systems and the EDS system can be developed using the enterprise service bus technology. The benefits include but are not limited to:

- Data would be entered one time. Each entity would enter data for their area of responsibility (local coordinators for enrollment, providers for the claims information, and medical personnel for the ARFs/DRFs). This data would be sent to EDS, via the enterprise service bus. EDS staff would not have to re-key any information. The claims data could then be sent, again via the enterprise service bus, to the CaST system for dissemination to the CDC.
- Electronic forms – this will save redundant data entry on the part of the local coordinators, EDS and Central Office and cut down on errors;
- Records in the system being accessible to all – coordinators indicate that much time is spent on tracking down women who receive services in one county and live in another. The concept of sharing data statewide has been successful in other systems, WiSACWIS for example; and
- Reporting – reporting would be consistent across entities. This could include the Local Activity Report (LAR) and re-enrollment, for example.

As the system is designed to interface with the providers' systems, EDS and CaST, the benefits rise significantly. Just some of them are:

- Error reduction – since the enrollment information could be entered into the system once, EDS would not have to re-key the data. Likewise, the City of Milwaukee could key their own enrollment forms, reducing the workload on Central Office staff. Many of the enrollment, claim, and reporting forms are handwritten. Attempting to read others' handwriting can be difficult. Also, if the system were made to be self-editing (that is, a form could not be submitted unless all mandatory fields were completed), it would be far less likely that essential data would be omitted when submitted.
- Claims error reduction – since the interface would exist between the providers' data systems, EDS, and Central Office, the information for the ARFs/DRFs could be entered once by the medical provider and electronically matched to the enrollment information and attached to the claim. This would greatly reduce the rate of rejected claims.

- Federal reporting – again, if an interface were realized, the data would not have to be corrected when it came time to compile reports for the CDC.

In the interim, we support the current efforts to revise the program's forms and recommend those forms be made available electronically as soon as possible. Fillable portable document format (pdf) forms, both on the DHFS web site and available through the Access database many local coordinators are using, would greatly assist the program in reducing errors.

It is also recommended the WWWP implement a change to the enrollment form currently on the web site. It should be made more clear that an individual cannot self-enroll in the WWWP and that forms completed by women need to be returned to the local coordinator, not to EDS.

Consideration should also be given to using the Access database sent to the WWWP from EDS (the data which is converted to the CaST system) to satisfy accountability needs under the consolidated contract. This would eliminate the need for separate reporting for breast and cervical cancer screening and diagnosis services through Local Activity reports. This would also free up local coordinator's time for other activities such as case management, enrollment, eligibility determination and outreach.

5. Billing and Provider Reimbursement

In order to clarify reimbursement polices and communicate this to parties we recommend that the WWWP:

- Review current policies for areas of better coordination with Medicare.

- Continue to explore options to expedite reimbursement including revising reporting forms and moving to electronic reporting to reduce the incidence of denied claims and delays in reimbursement. We support the efforts of WWWP staff and EDS to facilitate electronic billing.

- Continue efforts to clarify policies with the goal of providing changes sooner once problems are discovered.

- Continue to seek assistance from advisors such as the Wisconsin Medical Society and possibly a business consultant to improve the billing and provider reimbursement business function in central office. This review should focus on practices such as back dating, changing codes in central office and the need to ensure consistent clear-cut policy.

- Work to identify and clarify the major reason(s) claims are denied and use this information to improve billing procedures. This could include requesting that EDS generate reports showing the denial rate for claims by procedure code, provider type and area of the state as well as routinely getting reports on the reasons why claims are being denied. Based on this information, the WWWP

should establish new protocols and communicate them to all affected parties so that the number of denied claims will begin a downward trend.

- Work to clarify the denial letters sent to providers, to assure that what is needed in order to get claims paid is asked for succinctly.

6. Program Administration and Role of Various Partners

Role of Local Coordinators-- We recommend that the role of local coordinators be re-examined. Local coordinators report that they are not able to spend as much time as they should on WWWP functions such as case management, provider relations and outreach due to the time needed to resolve billing problems. Time spent with billing issues is often frustrating for local coordinators because they are only able to work on WWWP issues part time given their other job responsibilities and also because many local coordinators don't have the knowledge or expertise to deal with billing issues.

It is recommended that unless the coordinator's support is needed to assist women who have actually been billed for services they received through the WWWP, local coordinators should refer billing questions to central office or to EDS. There should be a protocol developed to help local coordinators decide the appropriate party (central office or EDS) to refer billing questions to. Coordinators then can concentrate on seeing that women receive recommended screening, counseling women who need assistance to get treatment for diagnosed conditions, and arranging support services such as transportation and child care so women can receive needed screening and diagnostic tests. Routinely referring billing questions to the central office or EDS also will make it easier to ensure that questions about billing are answered consistently and that central office is aware of the type of billing problems so they can take steps to address them.

Allocation of Resources.--We found that a relatively small share of the current WWWP budget is being used for reimbursing screening providers. We recommend that the WWWP program review the allocation of resources to increase the share of funds used to provide screening and diagnostic services to clients.

7. Program Impact

We found that key areas where the WWWP was not meeting its goals were screening; tracking, referral and follow up; and case management. A number of the recommendations cited above should make it easier for the program to meet these goals. Specific recommendations which, if implemented, would help the program focus on these goals include: revising the local coordinator's role related to billing issues, increasing the program's focus on breast and cervical cancer screening, modifying the current Expanded Component, and improving billing and program reporting procedures.

[1] A description of the Wisconsin Cancer Council can be found at: http://www.wicancer.org

[2] CDC Policies and Procedures Manual, Program Policies Attachment B: NBCCEDP "Allowable Procedures and Relevant 2004 CPT Codes." Dated November 2003.

[3] To qualify for Medicaid coverage under the program, a woman must be under age 65, not otherwise eligible for Medicaid, without creditable health care coverage, screened through the state's Breast and Cervical Cancer Early Detection Program, and be found to need treatment for breast and/or cervical cancer or precancerous conditions. CDC 2004/2005 Fact Sheet "The National Breast and Cervical Cancer Early Detection Program: Saving Lives Through Screening" at http://www.cdc.gov/cancer/nbccedp/about2004.htm

[4] The WWWP also does not cover additional testing used to determine a plan for treatment. For women with breast or cervical cancer diagnosed through the WWWP, this other testing is usually covered by the Well Woman Medicaid program.

[5]U. S., Preventive Services Task For "Screening Tests for Women of Different Ages" from http://www.cdc.gov/cancer/nbccedp/info-bc.htm

[6] WWWP Reminder on HPV Test Coverage for Wisconsin Well Woman Program Providers, April 14, 2004

[7] DHCF "Wisconsin Medicaid & BadgerCare Update "Family Planning Waiver Recipients May be Eligible for Wisconsin Well Woman Medicaid." June 2004. Published at: http://dhfs.wisconsin.gov/medicaid/updates/2004/2004-51.htm

[8] Prior to July 2004, only women ages 35-44 in the Medicaid Family Planning waiver could be enrolled in the Medicaid Well Woman Program. They would need to be disenrolled from the Family Planning Waiver and then enrolled in the WWWP before they could be enrolled in the Medicaid Well Woman Program. However, women in the Family Planning Waiver diagnosed with cervical cancer who subsequently enrolled in the WWWP would not be eligible for the Medicaid Well Woman Program because in order to be eligible, the cancer would have to be diagnosed while the woman was enrolled in the WWWP. (DHCF, Wisconsin and BadgerCare Medicaid Update July 2003, No. 2003-68).

[9] WI Health Care Account Quality Management System, Level 3, Eligibility WI Well Woman Procedures

[10] National Conference of State Legislatures Health Home Page, State Legislation Relating to the Breast and Cervical Cancer Prevention and Treatment Act of 2000. Published at http://www.ncsl.org/programs/health/cancerch.htm

[11] Wisconsin Medicaid Recipients, Wisconsin Medicaid Fact Sheet Wisconsin Well Woman Medicaid. Available at: http://dhfs.wisconsin.gov/medicaid1/recpubs/factsheets/phc10065.htm

[12] DHCF, Wisconsin Medicaid Fact Sheet, The Family Planning Waiver PHC 10068 (04/03).

[13] DHCF "Wisconsin Medicaid & BadgerCare Update "Family Planning Waiver Recipients May be Eligible for Wisconsin Well Woman Medicaid." June 2004. Published at: http://dhfs.wisconsin.gov/medicaid/updates/2004/2004-51.htm

[14] An exception to this is a pilot project operated in the city of Milwaukee. In the Milwaukee pilot project, the city's WWWP's fiscal agent can pay screening providers directly. Providers still must submit the required enrollment and activity reporting forms to MBCAP in order to be reimbursed.

[15] WWWP Draft Document "Revised "Billing, Reporting & Reimbursement" Directions, August 26, 2004.

[16] Summary based on payments from January 1, 2004-June 10, 2004, from the Margot Olmstead PIN Fund-2004. Provided by Nancy Rose, coordinator for Milwaukee suburban WWWP consortium.

[17] Wisconsin Well Woman Program Provider Information," April 2004.

[18] WWWP Monthly Update, September 22, 2004.

[19] WWWP Provider Information, April 2004.

[20] WWWP grant application for FFY 05.

[21] CDC 2004/2005 Fact Sheet "The National Breast and Cervical Cancer Early Detection Program: Saving Lives Through Screening" at http://www.cdc.gov/cancer/nbccedp/about2004.htm

Appendices

Appendix A-- Consolidated Contract Grants CY 2004
Appendix B-- State Legislation Establishing the Expanded Component
Appendix C-- WWWP Budget for FFY 2004
Appendix D-- WWWP Objectives from Federal Progress Reports
Appendix E-- DPH Response to Evaluation of WWWP

Appendix A--Consolidated Contract Grants CY 2004

No	County	Agency	Grant
1	Adams	Adams Co PHD	$16,485
2	Ashland	Ashland Co Health Dept	$13,776
3	Barron	Barron Co Health Dept	$24,908
4	Bayfield	Bayfield Co Health Dept	$14,026
5	Brown	Brown Co Health Dept	$57,000
6	Brown	DePere Dept Public Health	
7	Buffalo	Buffalo Co Health & Human Svc	$9,691
8	Burnett	Burnett Co Health Dept	$12,937
9	Calumet	Calumet Co Health Dept	$9,250
10	Chippewa	Chippewa Co Dept Public Health	$23,846
11	Clark	Clark Co Health Dept	$19,388
12	Columbia	Columbia Co Health Dept	$17,895
13	Crawford	Crawford Co Public Health	$12,848
14	Dane	Dane Co HSD	$80,861
15	Dane	Madison Dept Public Health	
16	Dodge	Dodge Co HSD & Health Dept	$18,956
17	Door	Door Co Health Dept	$16,371
18	Douglas	Douglas Co Health Dept	$24,241
19	Dunn	Dunn Co Health Dept	$16,746
20	Eau Claire	Eau Claire city/co Health Dept	$36,163
21	Florence	Florence Co Health Dept	$8,155
22	Fond du Lac	Fond du Lac Health Dept	$30,172
23	Forest	Forest Co Health Dept	$10,075
24	Grant	Grant Co Public Health Dept	$23,598
25	Green	Green Co Health Dept	$14,638
26	Green Lake	Green Lake Co Health Dept	$11,841
27	Iowa	Iowa Co Health Dept	$12,065
28	Iron	Iron Co Health Dept	$8,971
29	Jackson	Jackson Co H&HSD	$12,050
30	Jefferson	Jefferson Co Health Dept	$22,070
31	Jefferson	Watertown Dept Public Health	
32	Juneau	Juneau Co Health Dept	$16,335
33	Kenosha	Kenosha Co Div of Health	$52,506
34	Kewaunee	Kewaunee Co Health Dept	$10,763
35	LaCrosse	LaCrosse Co Health Dept	$37,438
36	Lafayette	Lafayette Co Health Dept	$11,522
37	Langlade	Langlade Co Health Dept	$15,641

38	Lincoln	Lincoln Co Health Dept	$15,083
29	Manitowoc	Manitowoc Co Health Dept	$27,812
30	Marathon	Marathon Co Health Dept	$38,292
31	Marinette	Marinette Co Health Dept	$24,935
32	Marquette	Marquette Co Health Dept	$11,277
33	Menominee	Menominee Co Human Svc	$9,046
34	Milwaukee	North Shore Health Dept	
35	Milwaukee	Cudahy Health Dept	
36	Milwaukee	Franklin Health Dept	
37	Milwaukee	Greendale Health Dept	
38	Milwaukee	Greenfield Health Dept	
39	Milwaukee	Hales Corners Health Dept	
40	Milwaukee	Milwaukee City Health Dept	$285,880
41	Milwaukee	Oak Creek Health Dept	
42	Milwaukee	St. Francis Health Dept	
43	Milwaukee	Shorewood Health Dept	
44	Milwaukee	South Milw Health Dept	
45	Milwaukee	Wauwatosa Health Dept	
46	Milwaukee	West Allis	$75,723
47	Milwaukee	Whitefish Bay/Shorewood	
48	Monroe	Monroe Co Health Dept	$22,151
49	Oconto	Oconto Co Health Dept	$18,506
50	Oneida	Oneida Co Health Dept	$19,082
51	Outagamie	Outagamie Co Hlth & Prev	$35,903
52	Outagamie	Appleton City Health Dept	
53	Ozaukee	Ozaukee Co Public Health Dept	$16,012
54	Pepin	Pepin Co Health Dept	$7,582
55	Pierce	Pierce Co Health Dept	$12,504
56	Polk	Polk Co Health Dept	$19,463
57	Portage	Portage Co DHHS	$22,937
58	Price	Price Co Health Dept	$11,699
59	Racine	City of Racine Health Dept	$80,127
60	Racine	Western Racine Health Dept	
61	Racine	Caledonia/Mt Pleasant	
62	Racine	Elmwood	
63	Racine	North Bay	
64	Racine	Sturtevant	
65	Richland	Richland Co Health Dept	$13,255
66	Rock	Rock Co Public Health Dept	$51,243
67	Rock	Beloit Health Dept	
68	Rusk	Rusk Co Health Dept	$13,194
69	St Croix	St Croix CO DHHS	$16,223
70	Sauk	Sauk Co Public Health Dept	$23,830
71	Sawyer	Sawyer Co DHHS	$15,753
72	Shawano	Shawano Co Health Dept	$21,629
73	Sheboygan	Sheboygan Co Human Serv	$28,287
74	Taylor	Taylor Co Health Dept	$12,091
75	Trempealeau	Trempealeau Co Health Dept	$14,247
76	Vernon	Vernon Co Health Dept	$18,793
77	Vilas	Vilas Co Health Dept	$15,930
78	Walworth	Walworth Co Health Dept	$28,481

79	Washburn	Washburn Co Health Dept	$13,094
80	Washington	Washington Co Health Dept	$22,608
81	Waukesha	Waukesha Co Health Dept	$53,393
82	Waupaca	Waupaca Co Human Serv	$24,085
83	Waushara	Waushara Co Health Dept	$15,480
84	Winnebago	Winnebago Co Health Dept	$41,937
85	Winnebago	City of Menasha Health Dept	
86	Winnebago	Neenah Dept of Public Health	
87	Winnebago	Oshkosh Health Dept	
88	Wood	Wood Co Health Dept	$30,495
			$1,951,290

donate, accept, distribute, or dispense cancer drugs or supplies needed to administer cancer drugs under the program.

(e) The maximum handling fee that a medical facility or pharmacy may charge for accepting, distributing, or dispensing donated cancer drugs or supplies needed to administer cancer drugs.

(f) A list of cancer drugs and supplies needed to administer cancer drugs, arranged by category or by individual cancer drug or supply, that the cancer drug repository program will accept for dispensing.

(g) A list of cancer drugs and supplies needed to administer cancer drugs, arranged by category or by individual cancer drug or supply, that the cancer drug repository program will not accept for dispensing. The list shall include a statement that specifies the reason that the cancer drug or supplies needed to administer a cancer drug are ineligible for donation.

History: 2003 a. 175, 327.

255.06 Well−woman program. (1) DEFINITIONS. In this section:

(a) "Hospital" has the meaning given in s. 50.33 (2).

(b) "Mammography" means the making of a record of a breast by passing X rays through a body to act on specially sensitized film.

(c) "Medicare" has the meaning given in s. 49.498 (1) (f).

(d) "Nurse practitioner" means a registered nurse licensed under ch. 441 or in a party state, as defined in s. 441.50 (2) (j), whose practice of professional nursing under s. 441.001 (4) includes performance of delegated medical services under the supervision of a physician, dentist, or podiatrist.

(e) "Poverty line" means the nonfarm federal poverty line for the continental United States, as defined by the federal department of labor under 42 USC 9902 (2).

(2) WELL WOMAN PROGRAM. From the appropriation under s. 20.435 (5) (cb), the department shall administer a well woman program to provide reimbursement for health care screenings, referrals, follow ups, and patient education provided to low income, underinsured, and uninsured women. Reimbursement to service providers under this section shall be at the rate of reimbursement for identical services provided under medicare, except that, if projected costs under this section exceed the amounts appropriated under s. 20.435 (5) (cb), the department shall modify services or reimbursement accordingly. Within this limitation, the department shall implement the well woman program to do all of the following:

(a) *Breast cancer screening services.* Provide not more than $422,600 in each fiscal year as reimbursement for the provision of breast cancer screening services to women who are aged 40 years or older, by a hospital or organization that has a mammography unit available for use and that is selected by the department under procedures established by the department. Recipients of services under this paragraph are subject to a copayment, payable to the service provider, for which the department shall reduce reimbursement to the service provider, as follows:

1. For a woman for whom 3rd party coverage for services is obtainable, payment by the source of the 3rd party coverage at full reasonable charge.

2. For a woman for whom 3rd party coverage for services is not obtainable and whose income is above 150% of the poverty line, a copayment for the provided service that is based on a sliding scale, as developed by the department, according to the woman's income.

3. For a woman for whom 3rd party coverage is not obtainable and whose income is at or below 150% of the poverty line, no copayment.

(b) *Media announcements and educational materials.* Allocate and expend at least $20,000 in each fiscal year to develop and provide media announcements and educational materials to promote breast cancer screening services that are available under pars. (a) and (c) and to promote health care screening services for women that are available under par. (e).

(c) *Breast cancer screenings using mobile mammography van.* Reimburse the city of Milwaukee public health department for up to $115,200 in each fiscal year for the performance of breast cancer screening activities with the use of a mobile mammography van.

(d) *Specialized training to for rural colposcopic examinations and activities.* Provide not more than $25,000 in each fiscal year as reimbursement for the provision of specialized training of nurse practitioners to perform, in rural areas, colposcopic examinations and follow up activities for the treatment of cervical cancer .

(e) *Health care screening, referral, follow−up, and patient education.* Reimburse service providers for the provision of health care screening, referral, follow up, and patient education to low income, underinsured, and uninsured women.

(f) *Women's health campaign.* Conduct a women's health campaign to do all of the following:

1. Increase women's awareness of issues that affect their health.

2. Reduce the prevalence of chronic and debilitating health conditions that affect women.

(g) *Osteoporosis prevention and education.* Conduct an osteoporosis prevention and education program to raise public awareness concerning the causes and nature of osteoporosis, the risk factors for developing osteoporosis, the value of prevention and early detection of osteoporosis, and options for diagnosing and treating osteoporosis.

(h) *Multiple sclerosis education.* Conduct a multiple sclerosis education program to raise public awareness concerning the causes and nature of multiple sclerosis and options for diagnosing and treating multiple sclerosis.

(i) *Multiple sclerosis services.* Allocate and expend at least $60,000 as reimbursement for the provision of multiple sclerosis services to women.

(3) SERVICE COORDINATION. The department shall coordinate the services provided under this section with the services provided under the minority health program under s. 146.185, to ensure that disparities in the health of women who are minority group members are adequately addressed.

History: 1991 a. 39 s. 3709, 3710, 3711; Stats. 1991 s. 146.0275; 1991 a. 269; 1993 a. 16; 1993 a. 27 s. 345; Stats. 1993 s. 255.06; 1995 a. 27; 1997 a. 27, 79; 2001 a. 16, 107, 109; 2003 a. 33.

255.08 Tanning facilities. (1) DEFINITIONS. In this section:

(a) "Phototherapy device" means equipment that emits ultraviolet radiation and is used in treating disease.

(b) "Tanning device" means equipment that emits electromagnetic radiation having wavelengths in the air between 200 and 400 nanometers and that is used for tanning of human skin and any equipment used with that equipment, including but not limited to protective eyewear, timers and handrails, except that "tanning device" does not include a phototherapy device used by a physician.

(c) "Tanning facility" means a place or business that provides persons access to a tanning device.

(2) PERMITS. (a) No person may operate a tanning facility without a permit that the department may, except as provided in ss. 250.041 and 254.115, issue under this subsection. The holder of a permit issued under this subsection shall display the permit in a conspicuous place at the tanning facility for which the permit is issued.

(b) Permits issued under this subsection shall expire annually on June 30. Except as provided in ss. 250.041 and 254.115, a permit applicant shall submit an application for a permit to the department on a form provided by the department with a permit fee established by the department by rule. The application shall

Appendix C -- WWWP Budget for FFY 2004

National BCCEDP (FFY 04 CDC grant)					
Federal Funds:		**Federal**			**Total**
Personnel			$644,331		
Fringe Benefits			$259,150		
Travel			$29,789		
Equipment			$0		
Supplies			$18,220		
Contractual Services	Screening Service Providers	$1,014,160			
	Service Coordination	**$600,000**			
	City of Milwaukee	**$100,000**			
	EDS - Process Payments	$150,000	$1,864,160		
Consultants	Mary Alice Trapp, RN	$1,500			
	DHFS, BIS	$24,000			
	MOU BHI/DHCF	$40,000	$65,500		
Other	Printing	$17,564			
	Telephone	$6,888			
	Postage	$7,749			
	Training	$2,583			
	Rent	$54,932			
	Insurance	$18,942			
	Copy costs	$3,444			
	Speakers/Trainers: Prof Ed	$25,000			
	Administrative Costs	$86,707	$223,809		
Indirect Charges			$47,036		
Subtotal Federal Funds			**$3,151,995**		

National BCCEDP 01/01/2004 - 06/29/2004 Unobligated Funds			
Federal Funds:		**Federal**	

Supplies			$6,100		
Contractual Services					
Screening Service Providers	Screening Services	$218,749			
American Cancer Society	Outreach Native American Women	$10,000			
UW-Madison School of Nursing	Web-Based Prof Ed	$10,000			
WI Women's Health Foundation-Rural Women's Health Programs	Recruit Rural Women 35-64	$10,000			
UW-Milw School of Nursing-Interdenominational B&C Ed & Outreach	Parish Nursing, etc.	$15,000			
Local Health Depts	Public Ed Campaign	$25,000			
EDS	Reimbursement system	$125,000	$413,749		
Consultants	Mayo Clinic	$7,500			
	John Shalkham, M.A., ACT(ASCP), CT(IAC) and Daniel F.I. Kurtycz, MD	$5,000	$12,500		
Subtotal Federal Funds Unobligated Funds			**$432,349**		
Grand Total all Federal Funds FFY '04					**$3,584,344**

GPR Funds from appropriation under s.20.435 (5) (cb)

State Funds:		**Federal**		**State GPR**	**Total**
WWWP CDC B&C Consol Contracts - Breast Screening ages 40 or >	255.06(2)(a)			**$422,600**	
WWWP CDC B&C Consol Contracts additional funds	255.06(2)(a)			**$386**	
Media announcements and Ed materials	255.06(2)(b)			$20,000	
Milwaukee Mobile mammography van	255.06(2)(c)			$115,200	
Training rural colposcopic for nurse practitioners.	255.06(2)(d)			$25,000	
WWWP Expansion Consolidated Contracts	255.06(2)(e)			**$696,920**	
EPI Support - Tech Assistance				$22,000	
WWWP - Education Outreach				$5,000	
WWWP - City of Milw Pilot				**$131,384**	

EDS - Provider Payments for screenings				$482,764	
EDS - Claims Processing				$208,352	
Women's Health Conference	Women's health campaign			$25,000	
WWWP - Expansion - Tribes				$3,094	
Multiple Sclerosis Ed & Services - $60,000 assigned for 2 yrs.**	255.06(2)(h) 255.06(2)(i)			$30,500	
Osteoporosis prevention and education				$0	
Total GPR				**$2,188,200**	**$2,188,200**

Combined State and Federal Funds Grand Total		**$5,772,544**

* The CDC grant is on a FFY basis, the GPR allocation is on a SFY basis and the consolidated contract is on a CY basis.
** This $60,000 was for 2 years, all other figures shown are annual allocations.

Administration Local Coordinators, Consolidated Contract 2004 - Service Coordination	Amount
Federal - Award 06/30/2003 - 06/29/2004	**$600,000**
Federal - City of Milwaukee	**$100,000**
State - WWWP CDC B&C - Consolidated Contracts	**$422,986**
State - WWWP City of Milwaukee Pilot	**$131,384**
State - WWWP Expansion - Consolidated Contracts	**$696,920**
Total Consol Contracts	**$1,951,290**

Appendix D -- WWWP Objectives from Federal Progress Reports

February 28, 2003

Program Component: MANAGEMENT

Objective 1: By November 1, 2002, the WWWP will have developed a formal plan for HIPAA implementation.

Objective 2: By June 29, 2003, the WWWP will be HIPPA compliant.

Objective 3: By June 29, 2003, the WWWP will develop a plan for annual linkages of the WWWP screening database with the cancer registry.

Objective 4: By October 15, 2002, the WWWP will have a provider list service in place.

Objective 5: By June 29, 2003, the WWWP program director will be a member of the core planning team for the development of Wisconsin's comprehensive cancer control plan.

Program Component: SCREENING

Objective 1: By June 29, 2003, WWWP will maintain at 5400 or increase the number of women who receive mammograms and pap smears.

Objective 2: By June 29, 2003, the WWWP will increase the number of screening examinations provided to the following women of priority populations ages 35.64:

African American women from 2000 to 2500
Asian/Pacific Islander women from 100 to 200
Native American women from 700 to 725
Hispanic women from 1500 to 1550.

Objective 3: By June 29, 2003 WWWP will maintain at 3500 or increase the number of women rescreened at appropriate intervals.

Objective 4: By June 29, 2003, 75% of women receiving mammograms through WWWP will be age 50-64.

Objective 5: By June 29, 2003, 20% of WWWP clients receiving pap smears will be women who have never or rarely been screened for cervical cancer.

Objective 6: By April 1, 2003, implement an HPV screening policy and begin screening for HPV statewide.

Program Component: TRACKING REFERRAL AND FOLLOWUP

Objective 1: By June 29, 2003 the median days between a WWWP abnormal paper smear result (includes HSIL and squamous cancer) and final diagnosis will decrease from 30 days to 28 days and from 12.5% to 10% not over 60 days.

Objective 2: By June 29, 2003, the median days between abnormal mammography results and final diagnosis for women will decrease from 21 days to 17 days and from 16.8% to 10% not over 60 days.

Objective 3: By June 29, 2003, the median days between diagnosis of CIN II, CIN III/CIS or invasive cancer of the cervix and treatment for women will decrease from 6.5 days to 5 days and from 25% to 10% not over 60 days.

Objective 4: By June 29, 2003, the median days between final diagnosis of breast cancer (in situ or invasive) and treatment for WWWP clients will decrease from 8 days to 7 days with not more than 1.0% over 60 days.

Objective 5: By June 29, 2003, the percentage of abnormal pap smears (includes HSIL and squamous cancer) for women having a complete work-up with a diagnostic procedure and final diagnosis recorded will increase from 88.9% to 100%, and the percentage comprised of lost to followup, refused, or pending will decrease from 11.1% to 10%.

Program Component: CASE MANAGEMENT

Objective 1: By June 1, 1003, the QA Workgroup will review and revise the case management policy as needed.

Objective 2: By June 1, 2003, the QA Coordinator will assess whether each WWWP client with a diagnosis of cancer needs case management services.

Objective 3: By June 30, 2003, the QA Workgroup will evaluate the delivery of case management services.

Objective 4: By June 1, 2003, the Case Management Coordinator will assess re-screening intervals.

Objective 5: By June 1, 2003, the Case Management Coordinator will assess the timeliness of diagnosis to treatment intervals.

Program Component: QUALITY ASSURANCE AND IMPROVEMENT

Objective 1: By June 29, 2003, the WWWP will increase to 100% the number of WWWP participating providers who followup on enrolled women with abnormal screening examination or test results.

Objective 2: By December 1, 2002, the QA Coordinator will identify program eligible women who have never or rarely been screened for cervical cancer.

Objective 3: By June 29, 2003, the WWWP will increase from 10% to 20% the number of women who have never or rarely been screened for cervical cancer.

Objective 4: By June 29, 2003, the QA Coordinator will conduct a program review of clinical systems to determine the frequency at which program providers are scheduling pap tests for WWWP enrolled women.

Objective 5: By June 29, 2003, the QA workgroup will implement the Cervical Cancer Policy to decrease overscreening of WWWP clients.

Objective 6: By December 1, 2002, the QA workgroup will have a formal process in place to monitor provider practice for cervical cancer screening intervals.

Objective 7: By June 29, 2003, the WWWP will increase the percentage of patient chart audits on WWWP participating providers from 1% to 5% to ensure that program providers use established clinical practice guidelines that have been reviewed by the medical advisory workgroup.

Program Component: PROFESSIONAL EDUCATION

Objective 1: By June 29, 2003, the WWWP will increase the number of health professionals trained in the early detection and control of breast cancer from 100 to 175 via diverse teaching strategies.

Objective 2: By June 29, 2003, the WWWP will increase the number of health professionals trained in the early detection and control of cervical cancer from 100 to 150 via diverse teaching strategies.

Objective 3: By June 29, 2003, provide assistance with skill-based education related to breast and cervical cancer screening and diagnosis to faculty in 5 institutions for students of medicine, nursing, and allied health services.

Program Component: PUBLIC EDUCATION AND OUTREACH

Objective 1: By June 29, 2003, develop and implement marketing strategies to increase public awareness of the WWWP, enrollment, screening and rescreening rates.

Objective 2: By June 29, 2003, implement targeted outreach strategies to increase cervical cancer screenings almost eligible, priority population women who have rarely or never been screened in the following counties: Barron, Dane, Fond du Lac, Kenosha, La Crosse, Milwaukee, Outagamie, Racine, Rock, Sheboygan, Winnebago, Wood.

Objective 3: By June 29, 2003, implement a plan to recruit, enroll and screen more Native American women living on the 11 reservations throughout Wisconsin.

Program Component: COALITION AND PARTNERSHIPS

Objective 1: By June 29, 2003, the WWWP will increase distribution of information to coalitions and partners on WWWP breast and cervical cancer early detention activities.

Objective 2: By June 29, 2003, the WWWP will increase the number of partners in the WWWP network, including professional associations, voluntary, community and consumer organizations, with special emphasis on partners who focus their activities on priority population women.

Objective 3: Develop an ongoing mechanism for coordinated planning and communication with the proposed comprehensive cancer program within the BCDPHP.

Program Component: SURVEILLANCE

Objective 1: By June 29, 2003, the patient data management system will remain as the first WWWP priority.

Objective 2: By June 29, 2003, update the number of uninsured Wisconsin women aged 40-64 at or below the 250% level of poverty by race, ethnicity, and county based on the 2000 Census.

Objective 3: By June 29, 2003 data for breast and cervical cancer mortality, morbidity, behavioral risk factors, and health service utilization will be collected, analyzed, interpreted, and shared.

Program Component: EVALUATION

Objective 1: By June 29, 2003, measure the WWWP performance standards and objectives for each workplan component for the 6/30/03 – 6/29/04 period.

Objective 2: By June 29, 2003, analyze the UWCCC collaboration efforts to assess WWWP quality, effectiveness and efficiency.

Objective 3: By June 29, 2003, use the analysis to aid in WWWP planning and decision-making for the 6/30/04 – 6/29/045 time period.

February 27, 2004

Program Component: MANAGEMENT

Objective 1: By June 29, 2004, the WWWP will be HIPAA compliant.

Objective 2: By December 31, 2003, the WWWP will develop a plan for annual linkages of the WWWP screening database with the Cancer Registry.

Objective 3: By September 30, 2003, the WWWP will have a provider list service in place.

Objective 4: Hold the Comprehensive Cancer Control (CCC) state partnership organizational meeting by September 30, 2003.

Objective 5: By January 31, 2004, the WWWP will have completed a study on the impact of the program's screening activities on breast and cervical mortality in Wisconsin.

Program Component: SCREENING

Objective 1: By June 29, 2004, WWWP will provide 6000 women with mammograms and pap smears.

Objective 2: By June 29, 2004, the WWWP will provide screening examinations to the following women of priority populations ages 35-64:

African American women from 2000
Asian/Pacific Islander women from 200
Native American women from 500
Hispanic women from 1500.

Objective 3: By June 29, 2004 WWWP will maintain at 3500 or increase the number of women rescreened at appropriate intervals.

Objective 4: By June 29, 2004, 75% of women receiving mammograms through WWWP will be age 50-64.

Objective 5: By June 29, 2004, 20% of WWWP clients receiving pap smears will be women who have never or rarely been screened for cervical cancer.

Program Component: TRACKING, REFERRAL AND FOLLOWUP

Objective 1: By June 30, 2004, the median days between a WWWP abnormal pap smear result (includes HSIL and squamous cancer) and final diagnosis will decrease from 27 days to 26 days and from 21.5% to 18% not over 60 days).

Objective 2: By June 30, 2004, the median days between abnormal mammography results and final diagnosis for women will decrease from 14 days to 12 days and from 11.8% to 10% not over 60 days.

Objective 3: By June 30, 2004, the median days between diagnosis of CINII, CIN III/CIS or invasive cancer of the cervix and treatment for women will decrease from 6.4 days to 5 days and from 16.3% to 15% not over 60 days.

Objective 4: By June 30, 2004, the median days between final diagnosis of breast cancer (in situ or invasive) and treatment for WWWP clients will decrease from 12.6 days to 10 days with not more than 10% over 60 days.

Objective 5: By June 30, 2004, the percentage of abnormal pap smears (includes HSIL and squamous cancer) for women having a complete work-up with a diagnostic procedure and final diagnosis recorded will increase from 85% to 90%, and the percentage comprised of lost to follow-up, refused or pending will decrease from 15% to 10%.

Objective 6: By June 30, 2004, the percentage of abnormal mammograms, abnormal CBE's or diagnostic work-ups planned for breast cancer with a diagnostic procedure and a final diagnosis will increase from 94.5% to 95%; and the percentage comprised of lost to follow-up, refused or pending will decrease from 5.5% to 5%.

Objective 7: By June 30, 2004, the number of women with a diagnosis of CIN II, CIN III, CIS or invasive cervical cancer will receive treatment with no more than 20% lost to follow-up, refused, not needed or pending.

Objective 8: By June 30, 2004, the number of women with a diagnosis of in-situ or invasive breast cancer will receive treatment with no more than 10% being lost to follow-up, refused, not needed or pending.

Objective 9: By June 30, 2004, the number of enrolled women being rescreened will increase from 34.4% to 40%.

Program Component: CASE MANAGEMENT

Objective 1: By January 1, 2004, the QA Workgroup will review and revise the case management policy as needed.

Objective 2: By March 1, 2004, the QA Coordinator will assess whether each WWWP client with a diagnosis of cancer needs case management services.

Objective 3: By March 1, 2004, the Case Management Coordinator will assess re-screening intervals.

Objective 4: By March 1, 2004, the Case Management Coordinator will assess the timeliness of diagnosis to treatment intervals.

Program Component: QUALITY ASSURANCE AND IMPROVEMENT

Objective 1: By June 29, 2004, the WWWP will increase to 95% the number of enrolled women with abnormal screening examination or test results who receive follow-up.

Objective 2: By March 1, 2004, the QA Coordinator will increase the number of eligible women who have never or rarely been screened for cervical cancer to 10%.

Objective 3: By June 29, 2004, the QA Coordinator will conduct a program review of clinical systems to determine the frequency at which program providers are scheduling pap tests for WWWP enrolled women.

Objective 4: By June 29, 2004, the QA workgroup will implement the Cervical Cancer Policy to decrease overscreening of WWWP clients.

Objective 5: By June 29, 2004, the WWWP will increase the percentage of patient chart audits on WWWP participating providers from 1% to 5% to ensure that program providers use established clinical practice guidelines that have been reviewed by the medical advisory workgroup.

Program Component: PROFESSIONAL EDUCATION

Objective 1: By June 29, 2004, the WWWP will increase the number of health professionals trained in the early detection and control of breast cancer from 100 to 175 via diverse teaching strategies.

Objective 2: By June 29, 2004, the WWWP will increase the number of health professionals trained in the early detection and control of cervical cancer from 100 to 150 via diverse teaching strategies.

Objective 3: By June 29, 2004, provide assistance with skill-based education related to breast and cervical cancer screening and diagnosis to faculty in 5 institutions for students of medicine, nursing, and allied health services.

Program Component: PUBLIC EDUCATION AND OUTREACH

Objective 1: By June 29, 2004, develop and implement marketing strategies to increase public awareness of the WWWP, enrollment, screening, and rescreening rates.

Objective 2: By June 29, 2004, implement targeted outreach strategies to increase cervical cancer screenings among eligible, priority population women who have rarely or never been screened, in the following counties: Barron, Dane, Fond du Lac, Kenosha, La Crosse, Milwaukee, Outagamie, Racine, Rock, Sheboygan, Winnebago, Wood.

Objective 3: By June 29, 2004, implement a plan to recruit, enroll and screen more Native American women living on the 11 reservations through Wisconsin.

Program Component: COALITIONS AND PARTNERSHIPS

Objective 1: By June 29, 2004, the WWWP will increase distribution of information to coalitions and partners on WWWP breast and cervical cancer early detection activities.

Objective 2: By June 29, 2004, the WWWP will increase the number of partners in the WWWP network, including professional associations, voluntary, community and consumer organizations, with special emphasis on partners who focus their activities on priority population women.

Objective 3: By June 29, 2004, develop an ongoing mechanism for coordinated planning and communication with the proposed comprehensive cancer program within the BCDPHP.

Program Component: SURVEILLANCE

Objective 1: By June 29, 2004, the patient data management system will remain as the first WWWP priority.

Objective 2: By June 29, 2004, data for breast and cervical cancer mortality, morbidity, behavioral risk factors, and health service utilization will be collected, analyzed, interpreted, and shared.

Program Component: EVALUATION

Objective 1: By June 29, 2004, measure the WWWP performance standards and objectives for each workplan component for the 6/30/2003 – June 29, 2004 period.

Objective 2: By June 29, 2004, analyze the UWCCC collaboration efforts to assess WWWP quality, effectiveness and efficiency.

Objective 3: By June 29, 2004, use the analysis to aid in WWWP planning and decision-making for the June 30, 2004 – June 29, 2005 period.

Appendix E -- DPH Response to Evaluation of WWWP

CORRESPONDENCE/MEMORANDUM **STATE OF WISCONSIN**
Division of Public Health

DATE: **June 30, 2005**

TO: Pat Cooper, Chief,
Section of Program Evaluation and Audit, OSF

FROM: Herb H. Bostrom, Interim Administrator

SUBJECT: **Evaluation of Wisconsin's Well Woman Program (WWWP), Response**

Attached is the Division of Public Health's response to the recommendations in the Evaluation of Wisconsin's Well Woman Program and our plan to implement the recommendations.

The Bureau and WWWP managers will use the plan to monitor the accomplishment of the identified tasks.

On behalf of the Division and Wisconsin Well Woman Program staff, I would like to thank you and your staff for your work and recommendations.

Wisconsin Well Woman Program
Summary of Recommendations and Proposed Follow Up Plan

June 29, 2005

Topics	Audit Recommendations	Program plan to address recommendation
1. Services Covered by WWWP		
	1a. Update list of services covered more often	Background: WWWP staff reviews covered services as part of the preparation of the CDC Annual Interim Progress Report (budget and work plan). CDC periodically convenes expert panels to review the evidence-based science and current clinical practice for breast and cervical cancer screening. CDC considers the recommendations from the expert panels and then reviews and revises their policies regarding covered services, including new screening technologies and distributes the information to state health agencies that modify their list of covered services accordingly and distributes to providers and case coordinating agencies. Action Steps: 1. Semiannually the WWWP will formally review and update the list of services covered by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). 2. The WWWP will also review and update the list of services covered by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) when CDC makes significant changes in allowable services. 3. In both situations, the WWWP will convene the "Clinical Issues Workgroup", discuss the clinical and fiscal impact of the changes, and make recommendations to the program director. 4. The program director will recommend changes to the Medical Director, Chronic Disease Programs who will concur or modify. WWWP staff will disseminate the information in a timely basis to local case coordination agencies, providers, contractors, clients and other appropriate agencies, organizations and individuals. WWWP Staff Responsible: Service Delivery Coordinator

	1.b. Provide better coverage for breast and cervical cancer 1.b.1. Audit suggests the Division direct the WWWP to reallocate more of the GPR funding in the Expanded Component to better support and fill gaps in breast and cervical cancer screening.	Background: DPH does not feel that a change in the statutory language is necessary in order to provide GPR funding for breast and cervical cancer screening services that are not covered by CDC. This reallocation will also enable the WWWP to provide breast cancer screening services to more women in the 35-49 age group. The WWWP will: Action Steps: 1. By November 1, 2005, convene the Clinical Issues Workgroup and review the breast and cervical cancer screening services currently covered by the WWWP. 2. By December 15, 2005 the Clinical Issues Workgroup will present the final recommendations to the WWWP Quality Assurance Coordinator. 3. By December 31, 2005, the Quality Assurance Coordinator will consolidate and present the workgroup's recommendations to the Program Director and Chronic Disease Medical Director. 4. By January 15, 2006 the Program Director and the Chronic Disease Coordinator will present their recommendations to the DPH Administrator for approval. 5. Upon approval, the WWWP will notify local case coordination agencies, providers, contractors, clients and other appropriate agencies, organizations and individuals. Timeframe for completion: June 30, 2006 WWWP Staff Responsible: Quality Assurance Coordinator
	1.b.2. Audit recommends the use of the mammography van should be re-examined.	Background: DPH believes that the City of Milwaukee's use of the mobile mammography van for public education is within the statutory intent of Wis. Stats. 255.06. However the WWWP is committed to working with the City of Milwaukee to expand breast and cervical cancer screening. Action Steps: 1. By August 1, 2005, the WWWP Program Director will convene a meeting with the City of Milwaukee MBCAP staff to review the use of the mobile mammography van and the interest in the City's requesting a revision of the

	1.b.3. GPR funds should be used for screenings instead of local coordinator's salaries.	statutory language to expand screening services. 2. By September 1, 2005, provide recommended statutory language to OSF by. WWWP Staff Responsible: Program Director Background: DPH sees the use of these funds ($422,600) as an investment in WWWP service coordination. The funds are used to support local efforts to outreach, in-take and case management of eligible women to ensure that they receive periodic screening and the early detection of breast and cervical cancer. The WWWP funds local coordinating agencies in accordance with s. 255.06(2) which allows reimbursement for health care screenings, referrals, follow-ups, and patient education. These funds are part of DPH's performance-based consolidated contract system.
	1.c. Simplify policies on services covered.	Background: WWWP will clarify and simplify selected policies: Action Steps 1. By August 1, 2005, convene an ad hoc workgroup, including DPH Regional staff and representatives of local coordinating agencies and review current policy on the coverage of ancillary services for breast biopsies. 2. By September 1, 2005 the workgroup makes recommendations to WWWP about the coverage of ancillary services for breast biopsies. 3. By September 15, 2005 convene an ad hoc committee to review and select up to five (5) policies the revision of which would reduce misunderstandings among providers who order tests and procedures not covered by WWWP. 4. By October 1, 2005 develop updated drafts of the revised policies for review and comment by a cross sample of providers. 5. By November 1, 2005, incorporate the provider inputs into the draft policies. 6. By December 1, 2005, present recommended policies to state health officer for approval. 7. By September 1, 2005 convene a workgroup to review the utilization of osteoporosis screening by providers and WWWP clients.

		8. By September 15, 2005 recommend to the state health officer the retention or elimination of osteoporosis screening as a WWWP covered service. 9. Upon approval or denial notify providers, case management agencies, contractors, clients and appropriate organizations and individuals. 10. Upon approval or denial make written policy changes to the Policy and Procedures Manual particularly Appendix 6 – Screening Guidelines for Covered Services, Appendix 10 – Screening Tools and Guidelines and the case management section. Post to the WWWP webpage. 11. Upon updating and distributing the policy changes utilize the WWWP Provider Pages of the Monthly Coordinator Updates to publicize the changes. Timeframe for Assessing Progress: January 1, 2006 Team Members Responsible: Professional Education Coordinator
	1.d. Communicate services covered and program limitations	Background: The WWWP provides local coordinating agencies with the Welcome to the WWWP brochures. These are given to newly enrolled and re-enrolling clients. The brochure provides general information about the WWWP and broadly describes WWWP covered services. Action Steps: 1. By August 1, 2005 update the "Welcome to the WWWP" brochure to include information on Multiple Sclerosis (MS) services, add new information and delete out-of-date. 2. By September 1, 2005 submit the updated "Welcome to the WWWP" brochure for printing. 2. By August 15, 2005 request "concept approval" to develop a WWWP wallet size card listing the covered services and important provider reminders for distribution via case management organizations to clients. 3. Upon "concept" approval of the WWWP wallet card, prepare a template and request a cost estimate from printing for an initial printing. 4. Distribute updated "Welcome to the WWWP" brochure and WWWP wallet cards to case coordination agencies.

		Timeframe for Assessing Progress: September 1, 2005 Team Members Responsible: Public/Professional Education Coordinator
	1.e. Initiate additional efforts to ensure understanding of WWWP provider agreements	Background: The WWWP will use the Provider Pages of the Monthly Coordinator Updates and the WWWP website to review in detail the contents of the WWWP provider agreements. WWWP will explore the possibility of developing a video detailing program agreements and general program information to be used by program providers and local case coordination agencies. Action Steps: 1. By August 15, 2005, WWWP will examine the costs and benefits of developing a video detailing the covered services policies for providers. 2. By August 31, 2005, WWWP will decide if the benefits of developing a video exceed the costs or if there are other options. 3. By September 15, 2005, WWWP will communicate to with case coordination agencies and providers the contents of the WWWP provider agreements. Timeframe for Assessing Progress: August 31, 2005 Team Members Responsible: Professional Education Coordinator
2. Expanded Component		
	2.a. Refocus WWWP to better support breast and cervical cancer screening i.e. re-examine the expanded component	Background: The Expanded Component was originally a separate program, the Wisconsin Well Woman Health Screening Program (WWHSP). WWHSP's intent was to provide comprehensive health screening, diagnosis, assessment, and related services for cardiovascular disease; breast and cervical cancers; osteoporosis; diabetes; mental health issues; and domestic abuse. In 1999, the WWHSP and the WWCCP merged to form the WWWP. In keeping with the original intent of the expanded component and the federal component the WWWP is a screening program for uninsured and underinsured women. In the 03-05 legislative session The DHFS prepared and submitted draft statutory language to revise s. 255.06(2) to allow WWWP to increase the financial

		resources for case management. Joint Finance Committee approved the statutory changes on June 6, 2005. This authority allows WWWP to allocate some GPR funding to case management to support breast and cervical cancer screening, resulting in a greater portion of federal funds utilized for breast and cervical cancer screening. Action Steps: 1. By August 1, 2005, the WWWP staff will review CDC's "Well-Integrated Screening and Evaluation for Women Across the Nation" (WISEWOMAN) Program) as a more focused model for WWWP. The WISEWOMAN Program uses breast and cervical cancer screening as the base services to focus on screening for chronic disease risk factors i.e. tobacco use, physical activity & nutrition, lifestyle intervention, and referral services to prevent cardiovascular diseases (CVDs). 2. By September 15, 2005, WWWP will convene the Clinical Issues Workgroup discuss and make recommendations about adopting the WISEWOMAN model. 3. By August 1, 2005, WWWP will request its contractor, EDS run, analyze and present to WWWP a report by August 31, 2005 from the Provider Participation database describing by provider and code which screening services are offered most frequently. 4. By September 15, 2005, WWWP staff will review and discuss the report 5. By September 30, 2005, WWWP will convene an ad hoc workgroup to review the data and report and make recommendations to WWWP and Clinical Issues Workgroup by October 15, 200 6. By November 1, 2005, based on the Clinical Issues Workgroup input WWWP will make final recommendations to the state health officer. 7. Upon approval, WWWP will notify providers, local service coordination agencies, contractors and appropriate organizations and individuals Timeframe for Completion: January 1, 2006

		Team Members Responsible: Service Delivery Coordinator, Quality Assurance Coordinator, Professional Education Coordinator
	2. b. Summarize information from Provider Participation Agreements	Action Steps – Same 2a Team Members Responsible: Operations Coordinator
	2.c. Centralize MS to 1 central office staff person	Background: Funding for the MS component is limited to $60,000 for the 03-05 biennial budget period. To maximize these resources, the WWWP partners with primary care providers, MS Centers and the Wisconsin Chapter of the National Multiple Sclerosis Society (NMSS) and local service coordination agencies. Local service coordinators are generally the first WWWP contact for women enrolling in the program and are therefore critical. The Program has tasked the local service coordinators to provide general MS information to all women at the time of enrollment or re-enrollment. Local coordinators will provide case management services to women needing referral for MS staged assessments.
	2.d. Further consideration to screening for ovarian cancer	Background: Ovarian cancer is difficult to detect. At this time there is no standard or routine screening test. WWWP can not use federal NBCCEDP funds for ovarian cancer screening and the state resources can not support routine ovarian cancer screening.
	2.e. Reduce the size of the current provider network	Background: The current provider agreements end on June 30, 2006. In concert with the expiration of the agreements, WWWP will explore reducing the size of the provider network to improve the quality of client care and to reduce administrative costs. WWWP will review the size and level of current provider participation balancing those parameters with client access to covered services especially in rural areas and among priority populations. WWWP will coordinate the reduction in the size of the provider network with the preparation of the 2006-2007 CDC Interim Progress Report (budget and workplan). Action Steps: 1. By August 1, 2005 WWWP will request from its contractor, EDS a report by September 1, 2005 describing and analyzing the geographic locations and level of participation i.e. number of clients and number and type of services provided by each current service provider. 2. By August 15, 2005 WWWP will review, discuss the report and draft recommendation to the state health officer about the criteria and the providers to

		be terminated from the WWWP. 3. Upon approval or modification, prepare and send termination letters to providers with little or no activity. Estimated date: September 30, 2005. 4. Inform service coordination agencies, contractors and appropriate organizations and individuals. 5. By December 15, 2005, prepare provider participation agreements for the period: July 1, 2006 through June 30, 2008. 6. By March 1, 2006, distribute the provider participation agreements with a return deadline of May 15, 2006. Timeframe for completion: June 30, 2006 Team Members Responsible: Operations Coordinator, Data Specialist
3. Communication and Coordination Among Various Parties		
	3.a. Reinstate annual meeting	Background: Previous CDC cooperative agreements included funding to support an annual statewide service coordinators' meeting. The meeting's cost was about $10,000. CDC no longer provides funding specifically for this purpose. The federal NBCCEDP component budget does not include funding for and annual coordinators' meeting. Action Steps: 1. By September 1, 2005, WWWP will work with partnering organizations and appropriate DPH programs to pool resources to support a one-day meeting in calendar year 2005. 2. If a formal meeting is not feasible, WWWP will pursue the use of "Media-site" technology for implementation in the fall 2005 3. By collaborating with other organizations/programs and through the use of technology, the program will be able to reinstate the annual meeting.

		Timeframe for Completion: November 30, 2005 Team Members Responsible: Professional Education Coordinator
	3. b.Continue monthly updates	Background: WWWP will continue providing the Monthly Coordinator Updates Action Steps: 1. WWWP will include periodic surveys with the monthly coordinator updates to solicit feedback from readers about current program issues. Team Members Responsible: Public/Professional Education Coordinator
	3.c. Opening lines of communication between LCA, RO, CO by attending more regional meetings	Background: WWWP central office staff attends as many Regional Coordinator meetings as possible. Additionally, WWWP central office staff schedule quarterly teleconference calls with DPH regional office staff. Action Steps: 1. By September 1, 2005, WWWP central office staff will invite local service coordinators to participate in the teleconferences. 2. Beginning in October 2005, WWWP will invite representatives of local coordinating agencies and DPH Regional Offices staff to be members of ad hoc workgroups. Timeframe for Assessing Progress: July 31, 2005 Team Members Responsible: Professional Education Coordinator
	3.d. Formation of a WWWP Advisory Group	Background: The Clinical Workgroup and the Wisconsin Cancer Council currently provide advice and clinical expertise to the program as needed The WWWP will continue using the Clinical Issues Workgroup and the Wisconsin Cancer Council as advisory groups for the program. To input from a wider variety of stakeholders, WWWP will expand the membership of the workgroup. Action Steps: 1. By September 1, 2005, WWWP will develop a survey of providers to identify their issues.

		2. By October 1, 2005, WWWP will develop, distribute and evaluate a client satisfaction survey. 3. By November 1. 2005, WWWP will solicit input from the service coordinators via the monthly coordinator update. 4. By December 1. 2005 WWWP will seek input from coordinators during their regional meetings Timeframe for Assessing Progress: August 31, 2005 Team Members Responsible: Quality Assurance Coordinator
	3.e. Issue a current detailed provider list	Background: The WWWP issues a quarterly provider listings sorted by county to all local coordinating agencies. The listing includes the providers' name, number, address, phone number and contact person. The "contact person" is not necessarily a "medical contact". In many cases the "contact" is an administrative and/or billing contact. Action Steps: 1. By September 1, 2005, WWWP will explore posting the detailed provider listing on the HAN. 2. By December 31, 2005, WWWP will explore posting the detailed provider list on the WI Well Woman Program's webpage. 3. By June 30, 2006, WWWP program will include an element of information for a "medical contact" in conjunction with the revised provider agreements, effective July 1, 2006. Timeframe for Assessing Progress: June 30, 2006 Team Members Responsible: Operations Coordinator
	3.f. Reconsider role of DPH Regional Offices	Background: For the budget period, June 30, 2005-June 29, 2006, the WWWP funds 2.5 FTEs in the regional DPH offices. The compensation costs total $128,551 Action Steps: 1. By August 1, 2005, WWWP will review the budget for the period: June 30, 2005-June 29, 2006 and present a list of options and a recommendation to the DPH Administrator.

		2. By December 31, 2005, implement the option selected. Timeframe for Assessing Progress: October 30, 2005 Team Members Responsible: Operations Coordinator .
4. Reporting requirements		
	4.a. Establish a statewide web-based data system	Background: WWWP is working with the Department's Division of Health Care Financing DHCF) on their new data system, named "Interchange". As a component of "Interchange", WWWP would establish a statewide web-based data system to meet the informational, operational, fiscal and administrative needs necessary to support the day-to-day management of provider and client data, as well as, claims processing. The WWWP is also exploring the development of a statewide web-based data system. In conjunction with this exploration, the WWWP is working with the DPH PHN Director and Division of Health Care Financing Staff on the inclusion of the enterprise service bus technology currently implemented by the Division of Electronic Technology in the Department of Administration. WWWP's goal is to have a statewide web-based system to help local coordinating agencies determine and verify enrollment; provide case management; maintain client records and complete local activity reports. Action Steps: 1. Quarterly WWWP will meet with Ted Ohslwager, DPH's PHIN manager to discuss the applicability of Enterprise Service Bus Technology to WWWP. 2. Monthly, WWWP will request inclusion of the InterChange Implementation on the agenda of the DPH and DHCF Administrators meetings. Timeframe for Assessing Progress: December 31, 2005 Team Members Responsible: Program Director, Operations Coordinator, Data Specialist

	4.b. Create fillable PDF forms and place on DHFS web site and available through Access	Background: The development and deployment of word fillable PDF forms and placement on DHFS web site and available through Access is part of the InterChange implementation. WWWP is working with the DHCF to: create a fillable PDF enrollment form to facilitate electronic enrollment. Action Steps: 1. By January 31, 2006 create a fillable PDF WWWP enrollment form (DPH 4818). 2. By February 28, 2006 create PDF fillable screening (ARF) forms (DPH 4723) and (DPH 4728) . 3. By March 31, 2006 create PDF fillable diagnostic (DRF) forms (DPH 4724 and DPH 4729). 4. By April 1, 2006 deploy the PDF fillable forms. Timeframe for Assessing Progress: December 31, 2005 Team Members Responsible: Service Delivery Coordinator and Operations Coordinator
	4.c.Correct/update current enrollment form on website so individuals don't self enroll	See Action steps under 4.a. and 4.b.
	4.d. Consider Access database for CC to satisfy accountability requirements	See Action steps under 4a.
5. Billing and provider reimbursement		
	5.a.Review policies for better coordination with MA	Background: WWWP will work with providers and review Medicare billing policies and procedures to identify WWWP claims processing and provider payment problems that could be resolved with available resources (e.g., technical changes in claims processing, staff and budget resources). Action steps: 1. By August 1, 2005 update the Service Delivery Coordinator's position

		description (DER-PERS-10) to include this responsibility. Timeframe for Assessing Progress: July 15, 2005 Team Members Responsible: Program Director, Service Delivery Coordinator
	5.b. Facilitate electronic billing	See action steps under 4.a.and 4.b.
	5.c. Improve policy change and implementation time	See action steps under 1.a.
	5.d. Improve billing and reimbursement	Background: The WWWP is updating provider billing information. When finalized, WWWP will share the information with providers and local coordinating agencies. See action steps under 4.a. and 4.b. Timeframe for Assessing Progress: June 30, 2006 Team Members Responsible: Professional Education Coordinator
	5.e. Decrease the number of denied claims with revised established procedures	Background: The WWWP will work with EDS to identify the major reasons claims are being denied. This information as well as other policy, procedure and reimbursement information will be used to look at ways to decrease the number of denied claims. Action steps: 1.See action steps under 7.a. 2. By August 31, 2005 WWWP will request of its contractor a synopsis by frequency of the major reasons claims were denied for the period: July 1, 2004-June 30, 2005. 3.By September 30, 2005, WWWP staff will analyze the report and develop an approach to reduce the number and frequency of selected reasons for claim denial. Timeframe for Assessing Progress: July 31, 2005 Team Members Responsible: Operations Coordinator
	5.f. Clarify denial letters	Background: .Current letters to providers denying payment contain a group of denial codes. Providers are not informed of the specific reason for denial. The WWWP will work with the EDS staff to revise the denial letters to improve their

		clarity and provide in specific terms the reason for denial of payment Timeframe for Assessing Progress: July 31, 2005 Team Members Responsible: Operations Coordinator
6. Program Administration and Role of Various Partners		
	6.a.Improve roles of LCA by decreasing billing problems	Please see 4a. and 4b.
	6. b Review allocation of resources	Please see 2.a.
7. Program Impact		
	7.a. Improve screening, tracking, referral and follow up and case management	Background: WWWP is making improvements in these areas. Action Steps: 1.By December 31, 2005 WWWP will revise the screening and diagnostic forms. 2. By June 30, 2006, WWWP will implement electronic enrollment and billing 3. By January 1, 2006 WWWP will update the list of WWWP breast and cervical cancer screening services. 4. By June 30, 2006, WWWP will reallocate some GPR funding towards breast and cervical cancer screening services. 5. By December 31,2006 WWWP will develop a statewide web-based data system to be used by local coordinating agencies. Timeframe for Assessing Progress: June 30, 2006 Team Members Responsible: Program Director, Operations Coordinator, Service Delivery Coordinator, Data Manager